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ABSTRACT

Designed to help administrators involved with the deinstitutionalization of Arizona's severely and profoundly handicapped children, the manual details cooperative planning decisions and describes components of the educational program which are different from those previously delivered to less handicapped children. In the first section, responsibility, location of services, and service procurement information is listed for the public schools and the Division of Developmental Disabilities/Mental Retardation. Eleven special considerations for the deinstitutionalized students (including assessment and programing resources, toilet training, transportation, and medical services) are discussed and resources are identified for each area. Three case studies are provided. Among five appendixes is information on placement into services from the community. (CL)

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Administrators Resource Manual
for the
Deinstitutionalization of Children and Youth

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on Deinstitutionalization

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INTRODUCTION

Deinstitutionalization of the mentally retarded and the profoundly handicapped represents one strand of a recent complex consciousness of civil rights of individuals in the United States. While the process of deinstitutionalization has been underway in various locales for several years, the success of the transfer of handicapped persons from institutions to what should be more normal, less restrictive environments has been mixed, depending on how well services in the community have been planned, coordinated and maintained. Another factor that has determined success or lack of success is how well the residents of institutions have been prepared for their move to the community.

The Education for All Handicapped Children Act (Public Law 94 142) strengthens the concept of equal opportunity for all school-aged persons; coupled with the deinstitutionalization movement, new types of educational services are mandated for a population of persons who heretofore have been mainly excluded from public school services.

The initiation of classes for the severely retarded and profoundly handicapped presents bold challenges for local school administrators. The rules and regulations, policies, territorial rights and traditions of several agencies which have operated autonomously in the past must be waded through, coped with, understood, and finally, made to work on behalf of each individual person who arrives at a school from an institution.

When the move toward deinstitutionalization began in Arizona, state level administrators in the Arizona State Department of Education (Division of Special Education) and the Bureau of Mental Retardation* called together a task force of administrators from local school districts, personnel from the Bureau of Child Development (Department of Health Services), and the two state agencies. At the request of the Division of Special Education, the Southwest Regional Resource Center facilitated and coordinated the meetings of task force members who met to design an administrators' manual which would help guide the transfer of students from institutions to public schools.

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* While this manual was in the final editing stage, the title, "Bureau of Mental Retardation" was changed to, "Division of Developmental Disabilities/Mental Retardation" (Department of Economic Security). The initials, BMR, had been used through the book; in most cases the initials have been changed to DD/MR. The organizational structure remains the same, however, for the delivery of services by what was the Bureau of Mental Retardation; the law, policies and procedures, etc., contained here remain unchanged.

Introduction (continued)

The immediate concern of the local school administrators was that the manual address the mechanics of the transfer: who is responsible, for what. The matrix which begins Section I of this document outlines the responsibilities of Special Education and of the Bureau of Mental Retardation. Following the matrix is information on how administrators from the two agencies can optimize planning opportunities.

Task force members felt that beyond identifying the immediate responsibilities of the two agencies, the manual should also address components of the educational program which would differ from those previously delivered to less handicapped students. Thus, Section II covers eleven components that must receive new consideration when the program involves more seriously impaired students. With a few exceptions, schools already have the eleven components in place for special education students. Others, however, such as toilet training, are not part of the established curriculum. Once the eleven components--either as additions to or as intensifications of present components--become part of the school's special education program, they will enhance the capabilities of the receiving schools to deliver appropriate programs to all handicapped children and youth. Section III contains three case histories of severely handicapped students now in Arizona public schools.

At the moment, students who will be entering the schools for the first time will come from four living situations: some will still live at the institution, but attend the public schools; some will come to school from foster homes; others will come from state-operated group homes; some will come from their natural homes. Because PL 94-142 mandates the active participation of the parent in the educational program of a handicapped child, the identification of who has the authority to serve as the guardian, foster parent or surrogate for the child is a priority.

Arizona is now beginning the second year of a five-year plan to move the individuals in the Arizona Training Programs and in the Arizona State Hospital into communities--and for those of school age, into public schools. The steps taken by schools now will facilitate the inclusion of children in the future who may never leave their natural families--children for whom the term "deinstitutionalization" will be meaningless. The work to be done by the involved agencies--state, district and local--between that day and this, however, is complex and demanding, but not impossible. It is the hope of the task force that this resource manual will smooth the transition steps for schools taking the first steps toward serving the severely mentally retarded and other profoundly handicapped persons from the institutions and communities.

GUIDE TO ABBREVIATIONS

ARS: Arizona Revised Statutes

ATP: Arizona Training Program(s) (located at Phoenix, Coolidge and Tucson)

BMR: Bureau of Mental Retardation; now part of the Division of Developmental Disabilities/Mental Retardation, Department of Economic Security

Conditions and Standards: Arizona Department of Education's *Special Education Conditions and Standards Relating to Identification and Placement*, July, 1978

DD/MR: Division of Developmental Disabilities/Mental Retardation

DES: Department of Economic Security

ERIC: Educational Resources Information Center, The Council for Exceptional Children, 1920 Association Drive, Reston, Virginia, 22091 (703-620-3660)

HB: House Bill; HB 2426, which was adopted by the 1978 Arizona State Legislature and incorporated into the Arizona Revised Statutes, comprises Appendix E

IEP: Individualized education program (required for each handicapped child in a public school program)

IPP: Individual program plan (written plan which encompasses all services to be delivered to a handicapped child served by the Division of Developmental Disabilities/Mental Retardation)

SSI: Supplemental Security Income (see Appendix D)

SECTION I

MATRIX
and
COOPERATIVE PLANNING

MATRIX

of Services, Responsibilities and Processes

from

The Division of Special Education

and

The Division of Developmental Disabilities/Mental Retardation

Infant Stimulation: The development of preschool age children and infants who are developmentally disabled is facilitated by instructing the parent on how to teach the child in their living setting. (Primarily ages 0 - 2)

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
DD/MR may provide infant stimulation and/or developmental day training as resources allow. DD/MR eligibility criteria: Child must be mentally retarded and a resident of Arizona.* (Mental Retardation is defined as a condition involving subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior which is manifested before age 18.) (The DD/MR recognizes the difficulty of accurately assessing intellectual functioning of young infants and children. For this reason, children between the ages of 0 - 3 will be determined eligible according to a standardized developmental scale which indicates a developmental delay and a high risk which will likely result in mental retardation in later years.) *See Eligibility for Bureau of Mental Retardation Services, Appendix A, p. 155.	Public schools may provide preschool services by using federal funds.	Infant stimulation services are provided primarily in the home setting of the child; periodically the child might be brought in to a center. Developmental day training services are typically provided in a school-type setting through a contracted agency; the services might be integrated into a regular day care center with proper support services.

Developmental Day Training: Sensory-motor, cognitive, communicative, social interactional, and behavioral training to preschool age children who are developmentally disabled. In addition, parents are instructed in the use of developmental training methods. (Primarily ages 3 - 4)

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School
If a public school provides a federally funded preschool program, the program may be provided in a public school setting.	Family contacts DD/MR intake case manager for the district.* Determination of eligibility. Placement into service, or placed on waiting list. DD/MR District Intake Offices: District I Maricopa County 275-7821 District II Pima County 882-5791 District III Yavapai County Coconino County Navajo County Apache County 779-3609 District IV Mohave County Yuma County 782-4343 District V Pinal County Gila County 723-4151 District VI Cochise County Graham County Greenlee County 432-5431 *See Appendix B, p. 159 for information on the intake process.	CHILD FIND Resource Directory provides information and referral services for preschool handicapped children through the Department of Education. Call toll-free CHILD FIND 800-352-5468 Maricopa County 255-5200

WHAT SERVICE? Education for School Age Children

Educational Services

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
DD/MR is responsible for all children who attend school in the Arizona Training Programs (ATPs).	Arizona Training Program Resident A public school in which ATP is located shall accept the referral of a student who resides at ATP. -Public school is paid from State Department of Education (Institutional Voucher) for education of child. DD/MR Community Alternative Resident -Public school district in which home is located is responsible to ensure child receives special education. -If parents of child live in another district, public school is paid for full cost of child's program from State Department of Education (Certificate of Educational Convenience). -If parents of child live in that district, the district pays full cost of special education for the child. Foster Child -Public school district in which home is located is responsible to ensure child receives special education.	Arizona Training Programs at Coolidge, Phoenix and Tucson or contracted, special-education approved, private programs.

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School
Public school in which the home (ATP, group home, foster home, or natural home) is located.	...the Department of Economic Security may request on behalf of a school aged handicapped child...that the school district in which such facility or home is located enroll such school aged child in the district... (HB-2426/ARS 15-1015 D, Appendix E, p. 173.)	...Such school district shall, upon such request by the Department of Economic Security, enroll such handicapped child and provide special education and related supportive services to such child... (HB 2426/ARS 15-1015D, Appendix E, p. 173.)
	DD/MR initiates referral for evaluation.	Public School, after receiving referral for evaluation, signed by the parent or authorized DD/MR representative, proceeds with further evalution (if needed), IEP conferences, etc., in accordance with special education Conditions and Standards. Additional information may be obtained from the toll-free number CHILD FIND 800-352-5468 Maricopa County 255-5200

WHAT SERVICE? Education for School Age Children

Educational Services (continued)

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
	Foster Child (continued) -Public School is paid for full cost of child's program from Department of Education (Certificate of Educational Convenience). Natural Home -Public school district in which home is located is responsible to ensure child receives special education. -Public school pays full cost of program from district budget (tax base).	

WHAT SERVICE? Education for School Age Children

Determination of Special Education Eligibility Through Assessment

DD/MR will provide all assessment information for initial referrals to public schools from ATP's and community residential alternatives. Initial referral information will include: 1. Reason for referral 2. Educationally relevant medical findings	Public schools are responsible for determining special education eligibility through assessment for all legal foster children and natural district residents. Public schools are responsible for all reevaluations of children referred from an ATP or community residential alternative.	ATP - Procedures outlined in the Conditions and Standards.

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School

Public Schools - Procedures outlined in the Conditions and Standards.	Contact DD/MR District Office.	Contact Public School District Office.

WHAT SERVICE? Education for School Age Children

Determination of Special Education Eligibility Through Assessment (continued)

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
(continued) 3. Educational history of the child 4. Determination whether the child's education problems are related to educational disadvantage 5. Developmental history of the child (including determination of language background) 6. Types of tests administered and results 7. Current vision and hearing screening results 8. Recommendation of specific goals and instructional objectives (Refer to HB 2426/ARS 15-1013 B. and Conditions and Standards, Public Schools 4.)		

WHAT SERVICE? Education for School Age Children

Program Placement and IEP Development

DD/MR is responsible for all children who attend school in ATP's.	Public schools are responsible for all children who are referred to and attend school in the public school.	ATP, or contracted to approved private school. Procedures outlined in the Conditions and Standards.

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School
Public school, or contracted to approved private school. Procedures outlined in the Conditions and Standards.	Contact DD/MR District Office.	Contact Public School District Office.

WHAT SERVICE? Education for School Age Children

Related Services: Transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
DD/MR is responsible for all children who attend school in ATP's.	Public schools are responsible for all children who are referred to and attend school in the public school.	ATP, or contracted to approved private school. Procedures outlined in the Conditions and Standards

WHAT SERVICE? Non-Educational Services for Children

Residential

Community Group Homes: A regular home setting which is staffed to provide the necessary training in daily living skills to the children who live there (typically 5 children live in each home; may be contracted through vendor or state-operated).

Developmental Home: Home of a family which is paid to train and care for a mentally retarded child in their own home (limit of 1 - 2 children per family).

DD/MR *may* provide any of the residential services described if a person meets DD/MR eligibility criteria and resources are available. Typically in each community group home started, one child from the "community" is admitted. Admissions to ATP's are closed.	Public schools are obligated to pay for residential placement if the child is placed by the school district for education.	Community Group Homes - communities throughout Arizona, preferably close to where the child's parents reside and where appropriate special education programs might be provided. Developmental Homes - communities throughout Arizona, preferably close to where the child's parents reside and where appropriate special education programs might be provided.

in children, counseling services, and medical services for diagnostic or evalution purposes. The term also includes school health services, social work services in schools and parent counseling and training. (See p. 77 for information on equipment resources and PL 89-313 funding.)

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	**DD/MR**	**Public School**
Public school, or contracted to approved private school. Procedures outlined in the Conditions and Standards.	Contact DD/MR District Office.	Contact Public School District.

Large Group and Institutional Care: Residential services at the Arizona Training Programs and within the community serving more than 8 individuals in one residential unit.

Respite Services: Temporary out-of-home residential care (temporary means 2 weeks or less).

	Family contacts DD/MR intake case manager for the district. (See Appendix B, p. 159.) Determination of eligibility. (See Appendix A, p. 155.) Placement into service, or placed on waiting list.	Public school meets with parents in Placement Conference following evaluation to determine the most appropriate educational setting. (See p. 137 for clarification on who serves as parent.)

WHAT SERVICE? Non-Educational Services for Children

Residential (continued)

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
		Large Group and Institutional Care - communities throughout Arizona, preferably close to where the child's parents reside and where appropriate special education programs might be provided. Respite Services - these may be located in family homes, group homes, or large group and institutional care settings.

WHAT SERVICE? Non-Educational Services for Children

Medical and Dental Services

DD/MR responsible for children who reside in State-operated or supported residential settings, including all mentally retarded foster care children.	No responsibility.	

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School

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WHAT SERVICE? Non-Educational Services for Children

Family Support Services

Sitter Services: Persons are trained as sitters for mentally retarded children and subsidized on a sliding fee scale.

In-Home Training: Staff are available to train parents in their home on how to deal with problem behaviors a mentally retarded child might demonstrate.

WHO IS RESPONSIBLE?		WHERE IS SERVICE
DD/MR	Public School	DD/MR
DD/MR *may* provide any of the family support services described if a person meets DD/MR eligibility criteria and resources are available.	Public schools are not obligated to provide support services to handicapped children except as specified in the Individualized Education Plan for educational services.	Family Support Services are located in communities throughout Arizona.

Socialization: Provides activities to facilitate the development of social skills and social values and encourages the development of interpersonal relationship skills, structured recreational activities.

Therapeutic Intervention: Provides structural, nonmedical treatment activities which are directed toward the resolution of personal and/or interpersonal-related problems.

LOCATED?	HOW IS SERVICE OBTAINED?	
Public School	DD/MR	Public School
	Family contacts DD/MR intake case manager for the district. Determination of eligibility. Placement into service, or placed on waiting list.	Through each handicapped child's individualized education program (IEP).

PUBLIC SCHOOL AND BUREAU OF MENTAL RETARDATION COOPERATIVE PLANNING

The Bureau of Mental Retardation plans to deinstitutionalize 300 persons residing at Arizona Training Programs by June 30, 1981. These 300 people are both adults and school-age children. This plan was presented to the Arizona legislature in FY78 and dollars were appropriated to the Bureau of Mental Retardation to continue the implementation of the deinstitutionalization plans for FY79.

In its plans for deinstitutionalization the Bureau of Mental Retardation has two distinct phases of planning:

1) OVERALL/STATEWIDE PLANNING

   Approximately one and one-half to two years in advance of actually receiving dollars, the Bureau of Mental Retardation develops budget requests based on its overall plans, including its priority of deinstitutionalization. This budget request reflects the types of residential settings to be developed (i.e., for mildly, moderately, or severely handicapped individuals), but it is not until the legislature actually appropriates dollars that the Bureau of Mental Retardation can draw up specific plans as to actual types and numbers of people to be deinstitutionalized during a particular fiscal year. This is not known until the legislature approves the budget, which is typically during June of the previous fiscal year.

2) Once the budget has been approved, the Bureau of Mental Retardation can specifically plan the expenditures of that money and make concrete decisions as to how many people are to move from Arizona Training Programs to community residential alternatives, what types of people, and who they are specifically. In some cases the Bureau of Mental Retardation may have requested and planned for dollars to move more people than is possible when the actual dollars are received.

Schools typically prepare their budget requests for the next school year from January to March of the previous year with approval of these budgets from May to June. This is at the same time that the Bureau of Mental Retardation is developing its overall plans. In order to adequately plan together, the Bureau of Mental Retardation should contact school districts between January and February to discuss the possibilities of developing community residential alternatives in their districts. Realizing that this is still in the Bureau of Mental Retardation's overall planning phase, the school district should then study the types of students that the Bureau of Mental Retardation plans to move, its capabilities to place students into existing programs, and expansion of existing programs or development of new programs to serve these students.

Other specific topics to address at this joint planning time is the technical assistance that the school district might need from the Bureau of Mental Retardation to adequately serve certain types of students, the planning and development of an adequate budget to serve additional students (which needs to take into account funding sources for these students, whether it is local or state), and the transfer of 89-313 funds from the institutional setting to the public-school setting. The 89-313 funds (a federal program under Title I) allow the Bureau of Mental Retardation to receive money to support the education of school-age students in the Arizona Training Programs; when these students move to local school programs, the school district then becomes eligible to apply for these funds which are based on an annual student count. Schools should also address personnel needs, and begin planning inservice of teachers and aides and acquisition of additional teaching and support staff if needed.

Realizing that neither the community residential alternative nor the school district program can be implemented without appropriate approval of budgets, it is imperative that both the Bureau of Mental Retardation and the school district work together to plan for appropriate services to deinstitutionalize the school-age population. If cooperative planning occurs, possibilities are enhanced for adequate school programs, logically developed in a fiscally responsible manner, when students move to community residential alternatives.

SECTION II

SPECIAL CONSIDERATIONS

1. WHO WRITES THE IEP?

The educational curriculum, special equipment, transportation, special health care, scheduling, and implementation of a program for a handicapped child revolves around the unique Individualized Education Program (IEP) developed specifically for that child, based on present functioning levels and actual needs. The persons who must be involved in writing the IEP are listed below. Although it may involve some extra time and effort, arranging for significant other persons to participate in writing the IEP may contribute greatly in developing the most effective program possible for a child; this is the one time during the year when all personnel involved in service delivery can develop a comprehensive plan for the specific child. IEP development and coordination for children in public schools are the responsibility of the local public school district.

Components	Resources
Required Participants:	Conditions and Standards, Public School 5.09
Representative of the public school	PL 94-142 Sec. 121a.344
The child's teacher	HB 2426/ARS 15-1015 D. and 36-554.01 B. (Appendix E, pp. 182 and 192)
The child's parent/guardian	
The child, where appropriate	See p. 25 for information on the Individual Program Plan (IPP) from the Division of Developmental Disabilities/ Mental Retardation (DD/MR)
A member of the evaluation team or another school representative who is knowledgeable about the evaluation and results (mandatory for the first IEP following evaluation)	See p. 137 for clarification of who serves as parent in different circumstances
Who else might contribute?	
DD/MR case manager?	
Teacher from student's prior placement	
Vocational educator?	
Physical therapist?	
Specialist in disability area?	

WHO WRITES THE IEP (continued)

Components	Resources
Who else might contribute: Physician knowledgeable in child's area of disability? Social worker? Nurse? Others?	
Does the IEP coordinate with the IPP?	HB 2426/ARS 15-1015 D, and 36-554.01B
What resources are available for helping develop IEPs for severely handicapped students?	Developing Effective Individualized Education Programs for Severely Handicapped Children and Youth, Norris G. Haring, ed. Available from Special Press, 724 So. Roosevelt, Columbus, Ohio, 43209. $11.45 prepaid.

Suggestions on Problem-Solving

Excerpted from:

Arizona Department of Economic Security
Bureau of Mental Retardation District 1
Individual Program Plan Procedures

1.0 INTRODUCTION

State of Arizona Bureau of Mental Retardation (BMR) has developed an Individual Program Plan (IPP) Policy which complies with the Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (AC/MR-DD), Public Law (P.L.) 94-142 (Education of Handicapped Children), P.L. 94-103 (Developmentally Disabled Act), and P.L. 504 (Vocational Rehabilitation Act). The BMR Policy provides a general framework for the development of an IPP process in each BMR District...

1.1. IPP DEFINITION

The individual program plan is a written plan of intervention and action that is developed on the basis of assessment results and modified at frequent intervals, with the participation of all concerned. It specifies goals and objectives and identifies a continuum of development, outlining projected progressive steps and the developmental consequences of services...

1.4. DECISION MAKING MODEL

1.4.1. The following guidelines have been established with regard to decision-making by the IPP team:

1.4.1.1. The IPP team shall be vested with the authority for individual decisions, including but not limited to monitoring progress within individual programs, specification of program changes, program moves, requests for special methods of management such as aversive consequences, need for programs or services not presently available and program termination.

1.4.1.2. Individual-centered decisions shall be based upon objective information rather than on assumptions, speculations, rumors or other sources without grounding in fact.

1.4.1.3. In some instances, factors outside the control of the IPP team may preclude the implementation of a decision. For example, budgetary limitations or lack of availability of services may make it impossible to provide the staff to implement a needed program change. Such limiting factors should be identified, whenever possible, at the time the team makes its decision. One team member may be assigned the responsibility of investigating the feasibility of implementing the objective and of reporting back to the team.

1.4.1.4. Within the IPP team, decision making shall be on a consensus model; that is, the group shall agree unanimously on each decision. That is necessary in view of the fact that although each team member represents a specialized area of knowledge or interest, the results of the team's decisions ultimately affect one individual. All team members must make an effort to resolve differences so that the individual is best served.

1.4.2. DEFINITION OF THE CONSENSUS DECISION-MAKING MODEL

[The decision by consensus quoted in Sec. 1.4.2. comes from Joining Together: Group Theory and Group Skills, David Johnson and Frank Johnson, Prentice-Hall, 1975.]

1.4.3. Whenever total agreement cannot be reached, the team is to consider:

1.4.3.1. Additional alternatives which may be acceptable to all parties, compromising among alternatives.

1.4.3.2. Requesting consultation with a specialist agreed on by the team.

1.4.3.3. Additional information which the team members may obtain to make it possible to make a decision.

1.4.3.4. Use of the appeal procedure by the person(s) not in agreement with the team recommendation. Disagreement with the team and intent to appeal a team recommendation is to be expressed at the team meeting whenever possible so that the above options can be explained prior to the appeal.

1.4.4. INDIVIDUAL-CENTERED DECISIONS

The IPP team has the primary responsibility for all individual-centered decisions including, but not limited to, the following:

1.4.4.1. Decisions regarding the establishment and priority ranking of long-term objectives as needed and as indicated by a comprehensive assessment and/or other program data.

1.4.4.2. Decisions regarding program entrance, program change or movement and program termination, again based on reliable assessment and programming data and in terms of specific objective criteria.

1.4.4.3. Decisions regarding emergency intervention such as mental health commitment, psychiatric hospitalization, the need for an aversive consequence or other actions which significantly affect the level or restrictiveness of services, or the capacity of the program to provide essential services.

Individual-centered decisions shall be based strictly upon individuals' needs as indicated by reliable, comprehensive, professional and informal assessment programming data.

Such decisions are to be recorded and not to be made on the basis of availability or nonavailability of a particular service, convenience to staff or agency, program or agency needs or priorities or any other factor which is not directly related to the individual's growth or development.

These factors may, of course, affect whether or not the individual's needs can be met. When external factors affect the implementation of a decision, the procedure for problem analysis will be followed.

The purpose of separating the needs identification process from a realistic assessment of what is available or possible is to assure that the individual's needs are properly identified, and that if the needs cannot be met, data are maintained to provide a basis for developing needed services, training or other resources.

2. ASSESSMENT RESOURCES

Underlying an appropriate program for a handicapped student is an appropriate assessment. Care must be taken that the educational evaluation or assessment instruments are unbiased for all children; additional precautions must be taken when the child to be evaluated is also severely impaired. Children who come into the public schools from an institution will bring with them many types of records. It is the responsibility of the school to determine if the evaluations are current, and if they provide the kinds of information needed to develop a meaningful program. If the evaluations are not adequate, perhaps other records are still at the institution, and could easily be obtained. If not, the school should arrange to have additional testing performed to assure that an appropriate program will be developed for each student.

Components	Resources
Transfer of records to school facility	
Does child already have current IEP?	
Does adequate information exist or will additional testing be needed? If so, what kinds of tests should be used?	See pp. 30-43 for assessment information.
Does the battery include:	Teacher Reference Manual for Assessment Instruments for the Severely Developmentally Impaired, by Kenneth L. Harris, et al. Southwest Regional Resource Center, 1977.
Global intellectual or overall functioning?	
Measure of receptive language?	
Developmental scale?	Assessment Instruments for Limited English Speaking Students: A Needs Analysis. National Institute of Education, 1200 19th St., N.W., Washington, D.C. 20208. Limited supply available free of charge.
Behavioral descriptions?	
Has the primary language of the home been determined? Of child?	
Will a translator/interpreter be needed?	
Vision and hearing screening	School nurse; Arizona Department of Health Services, Bureau of Maternal and Child Health.

2. Assessment Resources (continued)

Components	Resources
Other resources?	Assessing the Learning Disabled: Selected Instruments, by August J. Mauser, Ed.D. Academic Therapy Publications, 20 Commercial Bldg., Novado, California 94947. 1976. Second edition, 1977, paper $7.00 postpaid. Identifying Handicapped Children: A Guide to Casefinding, Screening, Diagnosis, Assessment, and Evaluation, edited by Lee Gross and Kennith W. Goin. Walker and Company, 720 Fifth Avenue, N.Y., N.Y., 10019. Paper $6.95, cloth, $8.95. Shipping. $1.00. Preschool Test Matrix: Individual Test Descriptions, by Wayne Johnson, Ed.D. Charles C. Thomas Publishing Company, 301-327 East Lawrence Ave., Springfield, Ill. 62717. Available April 1979, $24.75. If you are looking for assessment services for a particular child, you may receive helpful information from: CHILD FIND 800-352-5468 Maricopa County 255-5200. Consult with other local school districts.

A WORD ABOUT ASSESSMENT

The assessment of handicapped children and youth demands that a trained and properly certified practitioner administer and interpret the results of most of the tests. The information that follows has been compiled to present an overview for the administrator of the types of information that can be obtained from various tests.

The purpose for assessment of a handicapped student is to provide prescriptions for his/her education. It is important to assess the individual child's specific skill levels in a number of areas so that the child's program can be structured to meet the specific needs identified. These areas include ability levels, achievement, adaptive behavior, sensory acuity and perception, speech development, motor skill levels, personality, and vocational development.

Some formal assessment instruments which are acceptable for normal children are not appropriate for severely involved children when used in a standardized manner. However, many of these tests can provide considerable information about a handicapped child if they are adapted to meet the child's specific needs. The child should be screened initially to determine the nature of the involvement. Tests can then be selected which will assess specific skill levels including strengths and weaknesses. For example, a typical intelligence test may not be appropriate for a child, but one or two of the subtests may provide information which will be valuable in developing the educational program. If only a subtest is administered, the psychologist's report should note that the entire test was not given, and report the manner in which the administration was adapted.

Many handicapped students have untapped skills. They may be able to perform at a high level on specific tasks if the proper assessment tool is used. Often observations or developmental scales are most helpful. It may also be necessary to test for process deficits. Children may also be physically uncoordinated due to lack of experience rather than due to a physical handicap. All areas should be examined if the child's needs are to be met. Severely handicapped children are not significantly different from other students in many areas, and it should not be assumed that they cannot be tested. Often tests which are used for normal students can provide considerable information about these students.

Criterion-referenced tests are most useful for providing the type of information required for programming. It should be noted that standardized tests can be used in this same manner. The important information to obtain is whether or not a child has developed a specific skill necessary for further training.

The administration of any test should provide valuable information regarding problem-solving style, ability to follow directions, and the like which could be used in programming.

It is important to determine where the child fits into the ongoing educational process. Any testing techniques which can determine the child's skill levels will be effective in helping develop an appropriate program.

The following is not intended to be an exhaustive list of tests, but is provided to suggest the types of tests that can be used to assess handicapped students. Some of the tests listed will require adaptation while others are specifically designed for handicapped populations.

ADAPTIVE BEHAVIOR TESTS

The most useful devices for assessing the functional levels of handicapped students may be the infant development scales and the adaptive behavior scales. These are useful in planning specific programming and are helpful in evaluating many different areas of developmental functioning. Such areas include motor development, perceptual development, social skills, language, self-care, and general levels of ability. Some districts in Arizona have also developed effective adaptive behavior scales which can be obtained upon request.

Test	Description
AAMD Adaptive Behavior Scale	This scale provides a measuring device for assessment of the mentally handicapped, emotionally maladjusted, or developmentally impaired individual. It can be administered to children or adults and indicates the individual's coping ability and maladaptive behavior.
Bayley Infant Scales	This is a carefully standardized, well-planned, and comprehensive measure of infant development. It provides scores on mental and motor development plus behavioral ratings. It can be used to measure the developmental levels of severely impaired children.

Test	Description
The Bayley Scales of Infant Development: Modifications for Youngsters with Handicapped Conditions	This tool is designed to assess cognitive development in handicapped babies, two to thirty months, by circumventing the effects of their physical limitations. The standard Bayley is first administered and then a second score is achieved by modifying the standard procedures.
Callier-Azusa Scale	This is devised for the assessment of extremely impaired individuals, particularly the deaf/blind and the multiply handicapped. It can be used where other measures may be inappropriate. It provides information about motor development, perceptual development, daily living skills, and language development skills.
Denver Developmental Screening Test	This screening device assesses developmental levels in gross motor, fine motor-adaptive, and personal-social areas. It is inexpensive, quick, and easy to administer and evaluate.
Fairview Behavior Evaluation Battery for the Mentally Retarded	This is a screening device which provides independent scales for measuring self-help skills, development, social skills, and language skills and also provides a problem behavior record. Scales require nonverbal responses. Assessments cover all levels of mental impairment and generally measure abilities in the scales from birth to ten years.
Gesell Developmental Schedules	These instruments test mental growth through quantitative measurements of language, motor development, adaptive behavior and social behavior.
Infant Intelligence Scale (Cattell)	This test is a downward extension of the Stanford-Binet Scale standardized for children from 3 to 36 months. The person administering

Test	Description
	this scale must have considerable training. The testing materials appeal to children.
Lakeland Village Adaptive Behavior Grid	This is similar to the AAMD Adaptive Behavior Scale.
Portage Project Checklist	This tool is designed to provide a guide for teachers, nurses, or others who need to assess a child's present behaviors and plan educational goals. It is useful for both normal and handicapped students and is keyed to specific curriculum projects.
Preschool Attainment Record PAR	This is patterned after the Vineland Social Maturity Scale. It was devised to provide assessment for children who could not be assessed directly with traditional techniques. It measures ambulation, manipulation, rapport, communication, responsibility, information, ideation, and creativity. It provides a global score which yields an attainment age and an attainment quotient.
Primary Progress Assessment Chart of Social Development	This is intended to provide a visual impression of the child's development in social abilities. It includes a developmental scale in self-help skills, communication skills, socialization skills and occupation. It was constructed to assess young normal children or profoundly mentally handicapped children and adults. It is easy to administer and score and requires no special training.
TMR Performance Profile for the Severely and Moderately Retarded	This test was constructed to provide assistance to teachers of moderately and severely handicapped children. It provides a profile of the pupil's levels of functioning in a wide variety of daily activities which are common in curricula for the retarded. It assesses social

Test	Description
	behavior, self-care, communication, basic knowledge, practical skills, and body usage. It is criterion-referenced and does not provide norms.
Vineland Social Maturity Scale	This scale provides information about the social development of the individual. There is some indication that these scores are related to mental age and intelligence in younger children. It is administered by interviewing someone familiar with the child, so it can be used with children who are very difficult to test. Norms should be adapted when testing hard-of-hearing children. This may be necessary for other severely handicapped children as well. It is easy to administer and inexpensive.

INTELLIGENCE TESTS

Standard intelligence tests can be used with handicapped children but may require adaptation. Some children have handicaps which have not affected intelligence and, for them, the standardized tests may be appropriate.

Test	Description
Chicago Non-Verbal Examination	This is an individually administered scale which is suitable for cerebral palsy patients and other physically handicapped persons. It requires no verbal response. It is a fair test for deaf or hard-of-hearing youngsters. The scoring is tedious and reliability is somewhat low.
Columbia Mental Maturity Scale	This test was designed to measure the intelligence of handicapped children. It is a nonverbal test with minimum motor responses

Test	Description
	required. It has been used with deaf children and has been found to be beneficial as an intelligence measure. Care should be used in interpreting results as they may be somewhat misleading.
Goodenough-Harris Drawing Test	This test can provide a comparative developmental level for a child. While it can be scored casually, close attention to the instructions in the manual should yield reliable results. This test has some projective value in terms of personality assessment.
Haptic Intelligence Scale for Adult Blind	This is a nonverbal test patterned after the performance tests of the WAIS. It is interesting to take but is somewhat lengthy. It is intended to be administered with the verbal portion of the WAIS. It should be administered and scored with caution. It is not recommended for blind persons of low ability or those with emotional problems.
Hiskey-Nebraska Test of Learning Aptitude	This test evaluates deaf or hard-of-hearing persons by utilizing pantomime instructions. It may also be used with persons of foreign backgrounds. It is standardized for both hearing and deaf children.
Leiter International Performance Scale	This test evaluates perceptual matching, analogies, memory, etc. It consists of many items similar to those on verbal tests but requires no language. It is especially suited for use with handicapped children. It has good interest appeal and can be used to evaluate relatively dis-

Test	Description
	turbed deaf children who could not otherwise be tested. It is expensive. Care should be taken in interpreting IQ scores as the mean and standard deviations are unique. If the IQ is to be compared to other standard tests, the score will need to be changed to a standard score.
Merrill-Palmer Scale of Mental Tests	This test is constructed to serve as a substitute for, or supplement to, revisions of the Binet scale It is designed for children 18 months to 6 years old. It has a large proportion of performance subtests and has good provisions for handling refused tests. It requires adaptation for handicapped children.
The Ohwaki-Kohs Tactile Block Design Intelligence Test for the Blind	This test is structured for blind children ages 6 and above. Norms are based on the testing of Japanese children.
Peabody Picture Vocabulary Test	This is an easily administered intelligence test which provides a global score for an individual's language abilities. The test requires no expressive language skills and is therefore an appropriate measurement for gaining information on individuals with speech impairment, cerebral palsy, other developmental handicaps, or withdrawal tendencies. It can generally be administered in less than fifteen minutes.
Progressive Matrices (Raven)	This nonverbal test may be used with the mentally retarded, deaf, and language impaired. It measures innate educative ability through a single modality of performance.

Test	Description
	This is good as a second test to substantiate another more comprehensive intelligence test. It is easy to administer and score and is inexpensive. It may yield invalid scores of impulsive children who tend to respond randomly rather than with accuracy and care. The examiner should observe the child carefully to assure that he is really trying.
Randall's Island Performance Tests	This is a nonverbal instrument for measuring preschool children. It consists of a wide range of performance and manipulative tasks which, used by a competent examiner, provide diagnostic and insightful information. This test is relatively expensive, but valuable.
The Smith-Johnson Nonverbal Performance Scale	This test is useful in evaluating preschool deaf children and can also be used for other nonverbal handicapped children. It has been well standardized on a large sample.
Stanford-Binet Intelligence Test	This test must be administered by a trained diagnostician. It yields a global intelligence quotient. Individual subtests may be particularly useful in identifying program needs of handicapped children.
The Stanford-Ohwaki-Kohs Block Design Intelligence Test for the Blind	This is an American revision of the Ohwaki-Kohs Test. It is meant for blind and partially sighted individuals aged sixteen and over.
Wechsler Adult Intelligence Scale (WAIS)	This intelligence scale provides three scores, a full-scale intelligence score, a performance intelligence score, and a verbal intelligence score. Twelve sub-

Test	Description
	tests are available with scaled scores. Individual sections or subtests may be appropriate for handicapped children. The test must be given by a qualified diagnostician.
Wechsler Intelligence Scale for Children-Revised (WISC-R)	This test provides the same type of scores as the WAIS.
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	This has the same format as the WAIS and the WISC-R. Again, specific subtests should be selected for use with an atypical child.

LANGUAGE TESTS

Many of the children who are severely handicapped have difficulty with language. It is important to be able to identify problem areas and help them to establish communication.

Test	Description
Bzoch-League Receptive-Expressive Emergent Language Scale	This scale could provide information to teachers about the language abilities of individuals suspected of functioning below the mental age of three years. It consists of a developmental scale administered as an interview. It will provide a receptive language age and an expressive language age and a quotient for each.
Communicative Evaluation Chart from Infancy to Five Years	This chart is a means of gaining an impression of a child's overall abilities or disabilities in language and performance. It is a normal developmental scale and can be administered by anyone familiar with the child.
Modern Language Aptitude Test	This is a carefully constructed and useful instrument for assessing language aptitude in grades three through six. It appears to be both reliable and valid although it may assess a higher level of skills than some handicapped children possess.

Test	Description
Northwestern Syntax Screening Test	This is intended to be used as a screening instrument only. It assesses the ability of children 3 to 8 years old in comprehension and formation of basic sentence structure. It assesses both receptive and expressive language skills. Test scores are compared against a norm population.
Utah Test of Language Development	This is a standardized assessment device which establishes a general score relating to the language development of the individual. It provides a language age in receptive and expressive language functioning. It may not be adequately sensitive for severe levels of mental impairment.

SOCIAL MATURITY TESTS

Many tests which are normally used to assess an individual's personality style and emotional maturity may not be appropriate for children who have been institutionalized. Their poor performance may be due to lack of experience rather than to any severe emotional problems. Often the adaptive behavior scales or simple sentence completion tests will be most useful. Care should be taken in comparing these children to a population of children with normal experiential backgrounds. (Note that the adaptive behavior checklists are reviewed in a previous section.)

Test	Description
Cain-Levine Social Competency Scale	This scale is devised to rate the social competence of trainable, mentally handicapped children. Scales include self-help skills, social skills, initiative (self-direction), and communication. It is standardized on a retarded population and is administered by interviewing.

Test	Description
California Preschool Social Competency Scale	This test is designed to measure the social competency of preschool children. It produces a percentile score which compares a child against a norm population.
Draw-A-Person	This is a good screening device for detecting severe emotional problems. It is relatively nonverbal and is probably the most practical projective personality test for handicapped children. Its interpretation is subjective and it should only be used by a trained psychologist.
H.T.P. Technique	This is similar to the Draw-A-Person Test. It requires little verbal communication and affords the competent clinician some valuable insight into basic personality dynamics of the subject.
Make-A-Picture-Story Test (MAPS)	This is basically the same as the CAT or TAT (p. 41) except that this test has actual figures which can be moved around a stage and grouped in ways that are indicative of social and personality dynamics.
Rorschach Ink Blot Test	This test should be used with great caution in examining handicapped students. It should never be used unless the student and the psychologist can effectively communicate.
Rotter Incomplete Sentence Blank	This is useful with subjects who understand the vocabulary of the test. It has a sophisticated vocabulary which is sometimes simplified by an experienced

Test	Description
	examiner. It is probably not useful for nonverbal children.
Thematic Apperception Test (TAT) or Children's Apperception Test (CAT)	This test may be used effectively if the child and the psychologist are able to communicate effectively and if the child has had an adequate experiential background.

PERCEPTUAL FUNCTIONING TESTS

Many severely handicapped children exhibit perceptual problems. In planning programs for these students it may be helpful to be able to identify their particular style of learning in order to provide remediation and compensation for such deficits.

Test	Description
Auditory Discrimination Test (Wepman)	This test is most often used as a screening test of children's auditory discrimination abilities. It can easily be administered by any qualified professional. The test can be administered to speech impaired or cerebral palsied children.
Barsch Perceptual-Motor Battery	This screening inventory measures body parts identification, functional identification, rolling, spatial awareness, visual fixation and scanning, balance, body parts rhythm, and crawling.
Bender Visual Motor Gestalt Test	This test can provide information about the functional age of some children in regard to perceptual motor abilities. It is easily administered and scored. The test can be used as a personality assessment but requires sophistication in interpretation for such purpose. It is recommended for children from 4 to 10 years old but can be used for older handicapped children.

Test	Description
Haptic Letter Recognition Test	This test determines the ability to identify a letter from touch alone.
Illinois Test of Psycholinguistic Abilities (ITPA)	This test provides information on twelve areas of process skills: auditory association, verbal expression, grammatic closure, auditory reception, visual reception, visual sequential memory, auditory sequential memory, visual association, visual closure, manual expression, auditory closure, and sound blending. It is fairly complicated to administer and requires special training. It was designed to measure the psycholinguistic abilities and disabilities of moderate and mildly handicapped children.
Lincoln-Oseretsky Motor Development Scale	This is a revision of the Oseretsky Tests of Motor Proficiency and includes many items that deal with eye-hand coordination. Other items measure gross, unilateral and bilateral motor tasks, and finger dexterity. The test contains a minimum of cultural bias and can be used with the mentally deficient.
Marianne Frostig Developmental Test of Visual Perception	This test measures five operationally defined perceptual skills: eye-motor coordination, figure ground, constancy of shape, position in space, and spatial relationships.
Motor-Free Visual Perception Test	This test, standardized on children with motor impairments and physical handicaps, measures visual-perceptual abilities without involving motor components.
Purdue Perceptual-Motor Survey	This test evaluates balance and posture, body image and differentiation, perceptual-motor match, ocular control, and form perception. It yields 22 scores.

Test	Description
Southern California Kinesthesia and Tactile Perception Tests	This battery of six tests diagnoses disorders of somesthetic perception. It covers kinesthesia, manual form perception, finger identification, graphesthesia, localization of tactile stimuli, and double tactile stimuli perception.
The Southern California Sensory Integration Tests (Ayres)	This test is designed to help determine the nature of certain types of dysfunction. Many of the tests are derivatives of clinical procedures. The test can discriminate between children who possess sensory integrative dysfunctions and those who do not. It requires some sophistication to administer the test.

VOCATIONAL TESTS

Several types of tests can be included under the title of vocational testing because it is thought that the skills these tests measure all have an impact on the type of training which will be given to a handicapped student in preparing him/her to learn vocational skills. Such tests include those of motor functioning, interests, and specific vocational skills. Elaborate assessment systems that properly assess vocational interests and aptitudes are available through vocational rehabilitation agencies.

Test	Description
Minnesota Rate of Manipulation Test	This test measures the perceptual abilities necessary to match relative shapes and sizes. It consists of putting blocks from the table into a form in its proper space with as much speed as possible. The test provides norms for junior and senior high school boys and girls and adults. It also includes special instructions for administering the test to the blind.
Pennsylvania Bi-Manual Work Sample	This instrument tests motor skills by combining the basic elements of a relatively simple work situation.

TEST PUBLISHERS

AAMD Adaptive Behavior Scale
American Association on Mental Deficiency
5201 Connecticut Avenue, N.W.
Washington, D.C. 20015

Adolescent Emotional Factors Inventory
Personnel Research and Guidance, Inc.
1604 Spruce Street
Philadelphia, Pennsylvania 19103

Auditory Discrimination Test (Wepman)
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Barsch Perceptual-Motor Battery
Special Child Publications
4535 Union Bay Place NE
Seattle, Washington 98105

Bayley Scales of Infant Development
The Psychological Corporation
Polk and Geary
San Fransisco, California 94109

The Bayley Scales of Infant Development: Modifications for Youngsters with Handicapped Conditions
TMA Outreach Program
Suffolk Rehabilitation Center
159 Indian Head Road
Commack, New York 11725

Bender Visual Motor Gestalt Test
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Bzoch-League Receptive-Expressive Emergent Language Scale
Anhinga Press
P.O. Box 13501
Gainesville, Florida 32304

Cain-Levine Social Competency Scale
Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, California 94306

California Preschool Social Competency Scale
Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, California 94306

Callier-Azusa Scale
Callier Center for Communication Disorders
1966 Inwood Road
Dallas, Texas 75235

Chicago Non-Verbal Examination
Children's Apperception Test (CAT)
Psychological Corporation
Polk at Geary
San Francisco, California 94109

Columbia Mental Maturity Scale
Psychological Corporation
Polk at Geary
San Francisco, California 94109

Communicative Evaluation Chart from Infancy to Five Years
Educators Publishing Services, Inc.
75 Moulton Street
Cambridge, Massachusetts 02138

Crawford Small Parts Dexterity Test
Psychological Corporation
Polk at Geary
San Francisco, California 94109

Denver Developmental Screening Test
Ladoca Project and Publishing Foundation, Inc.
East 51st Avenue and Lincoln
Denver, Colorado 80216

A Developmental Screening Inventory
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Draw-A-Person
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Emotional Factors Inventory
Personnel Research and Guidance, Inc.
1604 Spruce Street
Philadelphia, Pennsylvania 19103

Fairview Behavior Evaluation Battery for the Mentally Retarded
Fairview State Hospital
Research Department
2501 Harbor Blvd.
Costa Mesa, California 92626

Gesell Developmental Schedules
The Psychological Corporation
Polk and Geary
San Francisco, California 94109

Goodenough-Harris Drawing Test
Psychological Corporation
Polk and Geary
San Francisco, California 94109

H.T.P. Technique
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Haptic Intelligence Scale for the Adult Blind
Psychology Research
Box 14, Technology Center
Chicago, Illinois 60616

Haptic Letter Recognition Test
Robert M. Wold, OD
353 H Street
Chula Vista, California 92010

Hayes Interim Binet
Perkins School for the Blind
175 North Beacon Street
Watertown, Massachusetts 02172

Hiskey-Nebraska Test of Learning Aptitude
Union College Press
Lincoln, Nebraska 59639

Illinois Test of Psycholinguistic Abilities (ITPA)
University of Illinois Press
Urbana, Illinois 61801

Infant Intelligence Scale (Cattell)
Psychological Corporation
Polk and Geary
San Francisco, California 94109

Lakeland Village Adaptive Behavior Grid
Lakeland Village
Medical Lake, Washington 99022

Leiter International Performance Scale
Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, California 90025

Lincoln-Oseretsky Motor Development Scale
C.H. Stoelting Company
424 North Homan Avenue
Chicago, Illinois 60624

Make a Picture Story (MATS)
Psychological Corporation
Polk at Geary
San Francisco, California 94109

Marianne Frostig Developmental Test of Visual Perception
Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, California 94306

Maxfield-Buchholz Social Maturity Scale
American Foundation for the Blind
15 West 16th Street
New York, New York 10011

Merrill-Palmer Scale of Mental Tests
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

Minnesota Multiphasic Personality Inventory (MMPI)
Psychological Corporation
Polk and Geary
San Francisco, California 94109

Minnesota Rate of Manipulation Test
Special Education Materials, Inc.
484 South Broadway
Yonkers, New York 10705

Modern Language Aptitude Test
The Psychological Corporation
Polk and Geary
San Francisco, California 94109

Motor-Free Visual Perception Test
Academic Therapy Publications
1539 Fourth Street
San Rafael, California 94901

Non-Language Learning Test
Personnel Research and Guidance, Inc.
1604 Spruce Street
Philadelphia, Pennsylvania 19103

Northwestern Syntax Screening Test
Northwestern University Press
Evanston, Illinois 60201

Overbrook Social Competency Scale
Personnel Research and Guidance, Inc.
1604 Spruce Street
Philadelphia, Pennsylvania 19103

Peabody Picture Vocabulary Test
American Guidance Service, Inc.
Publishers Building
Circle Pines, Minnesota 55014

Penn Bi-Manual Worksample
Educational Testing Bureau
Publisher's Building
Circle Pines, Minnesota 35014

Perkins Binet
Perkins School for the Blind
175 North Beacon Street
Watertown, Massachusetts 02172

Portage Project Checklist
Cooperative Educational Services Agency #12
Portage, Wisconsin 53901

Preschool Attainment Record (PAR)
American Guidance Services, Inc.
Publisher's Building
Circle Plains, Minnesota 55014

PRG Interest Inventory for Blind
Personnel Research and Guidance, Inc.
1604 Spruce Street
Philadelphia, Pennsylvania 19103

The Primary Progress Assessment Chart of Social Development
National Association for Mental Health
39 Queen Anne Street, W. 1
London, England

Purdue Perceptual-Motor Survey
Charles E. Merrill Publishing Company
1300 Alum Creek Drive
Columbus, Ohio 43216

Raven's Progressive Matrices
Rorschach Ink Blot Test
Rotter Incomplete Sentences Blank
Psychological Corporation
Polk at Geary
San Francisco, California 94109

Roughness Discrimination Test
American Printing House for the Blind
1839 Frankfort Avenue
Louisville, Kentucky 40206

Scholastic Aptitude Test -- Braille or large print
Educational Testing Service
Princeton, N.J. 08540

School and College Ability Tests -- Braille or large print
Sequential Tests of Educational Progress -- Braille or large print
American Printing House for the Blind
1839 Frankfort Avenue
Louisville, Kentucky 40206

The Smith-Johnson Non-verbal Performance Scale
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

The Sound Test
Dr. Robert J. Teare
185 Kings Road
Athens, Georgia 30601

Southern California Kinesthesia and Tactile Perception Tests
Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, California 90025

The Southern California Sensory Integration Tests
Special Education Materials, Inc.
484 South Broadway
Yonkers, New York 10705

Stanford Achievement Test -- Braille or large print
American Printing House for the Blind
1839 Frankfort Avenue
Louisville, Kentucky 40206

Stanford-Binet Intelligence Scale
Houghton-Mifflin Company
777 California Ave.
Palo Alto, California 84304

Stanford-Ohwaki-Kohs Block Design Test
Nathan P. Bauman
400 Orchard Lane
Fort Washington, Pennsylvania 19034

Tactual Reproduction Pegboard
Dr. Robert J. Teare
185 Kings Road
Athens, Georgia 30601

Thematic Apperception Test (TAT)
Psychological Corporation
Polk and Geary
San Francisco, California 94109

TMR Performance Profile for the Severely and Moderately Retarded
Reporting Services for Children
563 Westview Avenue
Ridgefield, New Jersey 07657

Utah Test of Language Development
Communications Research Associates
Box 11012
Salt Lake City, Utah 84111

Vineland Social Maturity Scale
American Guidance Service, Inc.
Publisher's Building
Circle Pines, Minnesota 35014

Vocational Intelligence Scale for the Adult Blind
Dr. Robert J. Teare
185 Kings Road
Athens, Georgia 30601

Wechsler Adult Intelligence Scale (WAIS)
Wechsler Intelligence Scale for Children-Revised (WISC-R)
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)
Psychological Corporation
Polk and Geary
San Francisco, California 94109

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Tiffin, J. (Project Director). _An Investigation of Vocational Success with the Blind_. Lafayette, Ind., Purdue Research Foundation, Purdue University, 1960.

3. PROGRAMMING RESOURCES

The curriculum, content, and methods used in developing and implementing an educational program for a handicapped student all must be chosen with care. The program must work toward the student's attainment of the IEP's short-term objectives and annual goals. If a severely impaired student is to ever, in his or her school career, develop a feeling of self-worth and dignity, it will be through successes realized in an appropriate program.

Components	Resources
Base on needs and plans formulated expressly for the individual. Programming: curricula and methods.	The student's IEP. "Curriculum Guides for Developmentally Disabled Children: Severely Handicapped and Early Childhood," by Diane Renne. See pp. 56-60. Publications List. American Association for the Education of the Severely and Profoundly Handicapped. See pp. 61-64. The AAESPH also publishes a Materials List (82 pages) which includes sections on curricula, legal considerations, behavior modification, and bibliographies. Establishing Services for the Severely Handicapped in Public Schools, by Susan Harrison and Merrill Johnson. Southwest Regional Resource Center. Available from ERIC. Microfiche, .83; paper copy, $15.39 plus $1.02 postage.

3. Programming Resources (continued)

Components	Resources
Programming: curricula and methods (continued).	Research to Practice in Mental Retardation: Volume II, Education and Training, by Peter Mittler, ed. University Park Press, 233 E. Redwood St., Baltimore, Maryland, 21202. 1977. $24.50 plus $1.40 postage. Developing Effective Individual Education Programs for Severely Handicapped Children and Youth, Norris G. Haring, ed. Available from Special Press, 724 So. Roosevelt, Columbus, Ohio, 43209. $11.45 prepaid. The following are available from Council for Exceptional Children, Publication Sales, 1920 Association Drive, Reston, Virginia, 22091: Educational Programming for the Severely and Profoundly Handicapped, Ed Sontag, ed. $14.95 prepaid. Abstracts: The Mentally Retarded: Teaching Methods and Curricula. #812. $4.50 Abstracts: The Severely Mentally Handicapped: Teaching Methods and Curricula. #816. $4.50

CURRICULUM GUIDES FOR DEVELOPMENTALLY DISABLED CHILDREN: SEVERELY HANDICAPPED AND EARLY CHILDHOOD

Diane Renne, Ed.D.

Babbitt, P. & Zimmerman, D. Severe/Profound Handicapped Children: An Integrated Activity System for Hand Function and Language. Albuquerque, N.M.: Esperanza Para Nuestros Ninos, P.O. Box 12212, 1976.

Areas covered: Hand function, language.

Format: Screening checklists; activity card file with behavioral objective, materials and procedures for each activity.

Developmental level: 3 months to 3 years.

Bender, M. & Valletutti, P.J. Teaching the Moderately and Severely Handicapped. Vol. 1: Behavior, Self-Care, and Motor Skills; Vol. 2: Communication, Socialization, Safety and Leisure Time Skills; Vol. 3: Functional Academics for the Mildly and Moderately Handicapped. Baltimore, Md.: University Park Press, 1976.

Areas covered: Behavior, self-care, motor, communication, socialization, safety, leisure time skills, functional academics.

Format: Diagnostic checklists; general objectives, specific objectives, suggested activities for each specific objective.

Developmental level: Not specified.

Donahue, et. al. Parent/Child Home Stimulation, "The Marshalltown Project." Marshalltown, Iowa: Department of Special Education, Marshall-Poweshiek Joint County School System, 9 Westwood Drive.

Areas covered: Communication, motor and social.

Format: Assessment profile; prescription for each item on the profile including behavioral definition, appropriate cues, measurement criteria, materials sequenced subobjectives, teaching strategies.

Developmental level: Birth through 6 years.

Curriculum Guides. . .(continued)

Fredericks, H.D.B., et. al. The Teaching Research Curriculum for Moderately and Severely Handicapped. Springfield, Il.: Charles C. Thomas, 1976.

Areas covered:	Motor development, receptive oral language, expressive oral language, self-help skills, reading skills, writing skills, cognitive skills.
Format:	Placement tests; task analyzed teaching sequences.
Developmental level:	Preschool.

Henderson, S. & McDonald, M. Step-By-Step Dressing. Bellevue, Wash.: Edmark Associates, 1973.

Areas covered:	Dressing and undressing.
Format:	Sequences of steps for specific dressing skills, presented in chart form; sample lesson plans and teaching procedures.
Developmental level:	1 to 6 years.

Jones, J., et. al. Curriculum and Monitoring System. Logan, Ut.: Utah State University Affiliated Exceptional Child Center, 1977.

Areas covered:	Receptive language, expressive language, motor, self-help, social-emotional.
Format:	Placement tests for each area; task-analyzed instructional objectives with teaching procedures, photographs of body positions in motor and self-help sections.
Developmental level:	Young children, approximately 0 to 6 years.

Kent, L.R. Language Acquisition Program for the Retarded or Multiply Impaired. Champaign, Il.: Research Press, 1974.

Areas covered:	Preverbal, verbal-receptive, verbal-expressive, sign language and total communication.
Format:	Sequential teaching tasks, with procedures and criteria specified.
Developmental level:	Not specified.

Curriculum Guides. . .(continued)

Popovich, D. A Prescriptive Behavioral Checklist for the Severely and Profoundly Retarded. Baltimore: University Park Press, 1977.

Areas covered: Motor development, eye-hand coordination, language development, physical eating problems.

Format: Sequential checklist of skills in each area; instructional objective task analysis, description of materials, prerequisite skills, and procedures for each skill on the checklist.

Developmental level: Not specified; skills appear to all be preschool level.

Quick, A.D., Little, Thomas L. & Campbell, A.A. Project Memphis: Enhancing Developmental Progress in Preschool Exceptional Children. Belmont, Ca.: Fearon Publishers, 1974.

Areas covered: Personal-social, gross motor, fine motor, language, perceptuocognitive.

Format: Assessment scale, skill assignment record, continuous record of educational gain, sample lesson plans.

Developmental level: Newborn to 5 years.

Schafer, D.S. & Moersch, M.D. (eds). Developmental Programming for Infants and Young Children. Ann Arbor: The University of Michigan Press, 1977.

Areas covered: Perceptual/fine motor, cognition, language, social/emotional, self-care, gross motor.

Format: Developmental profile; short term goals, suggested activities, recommended adaptations for hearing, vision and motor impairments.

Developmental level: Newborn through 36 months.

Curriculum Guides. . .(continued)

Schafer, D.S. & Moersch, M.S. (eds). Developmental Teaching Guide. Boston: Boston Center for Blind Children, 147 South Huntington Ave.

Areas covered: Self-help, language, motor, social, orientation and mobility.

Format: Developmental checklist; activity file with activities matched to each item on the checklist.

Developmental level: Not specified; intended for use with visually impaired multiply handicapped children birth to 8 years.

Shearer, et. al. The Portage Guide to Early Education. Portage, Wi.: CESA 12, Box 564, 1976.

Areas covered: Infant stimulation, socialization, language, self-help, cognitive, motor.

Format: Checklist of skills in each area; curriculum card for each skill on the checklist.

Developmental level: Birth through 6 years.

Wabash Center for the Mentally Retarded. Guide to Early Developmental Training. Lafayette, In.: Wabash Center Sheltered Workshop.

Areas covered: Motor, cognitive, self-care, language.

Format: Assessment checklists; suggested activities for each of the skills covered in the checklists.

Developmental level: Birth through 6 years.

OTHER CURRICULA

Alpern & Boll Education and Care of Moderately and Severely Retarded Children.

Cibiri & Jackson Training Developmentally Handicapped Persons, Basic Life Skills.

Martin, et. al. The MIMR Basic Behavior Test, Curriculum Guide, Programming Strategy.

McCormack & Chalmers Systematic Instruction of the Severely/Moderately Handicapped.

AAESPH PUBLICATIONS LIST

3. PROG.

Books

Teaching the Severely Handicapped, Volume 1 and Teaching the Severely Handicapped, Volume 2 edited by Norris G. Haring and Louis J. Brown. $19.50 each--postpaid. Order from: Order Department, Grune & Stratton, 111 Fifth Ave., New York, NY 10003.

Teaching the Severely Handicapped, Volume 3, edited by Norris G. Haring and Diane Bricker. $15.95 each--plus $1.00 for postage and handling--$1.50 for Canada. Order from: Special Press, Dept. R3, 724 South Roosevelt Ave., Columbus, OH 43209.

Developing Effective I.E.P. s for Severely Handicapped Children and Youth, edited by Norris G. Haring. $10.95 each--plus $.50 for postage and handling--$1.00 for Canada. Order from: Special Press, Dept. R2, 724 South Roosevelt Ave., Columbus, OH 43209.

Beyond the Ordinary: The Preparation of Professionals to Educate the Severely and Profoundly Handicapped, edited by Robert Perske and Judy Smith. $5.50 postpaid--plus Washington State Sales Tax for Washington State residents. Order from: The American Association for the Education of the Severely/Profoundly Handicapped, 1600 West Armory Way, Seattle, WA 98119.

Mealtimes for Severely and Profoundly Handicapped Persons, edited by Robert Perske, Andrew Clifton, Barbara M. McLean and Jean Stein. $7.95 postpaid. Order from: University Park Press, Chamber of Commerce Building, Baltimore, MD 21202.

Papers

$1 per copy

American Association for the Education of the Severely/Profoundly Handicapped. Annotated bibliography.

Friedle, M. & Fox, L. A selected bibliography (partially annotated) related to the vocational training of severely handicapped persons.

Hamre, S. An approximation of an instructional model for developing home living skills in severely handicapped students.

Tawney, J.W. Developing curricula for errorless learning: A search for order in an unorderly world.

Williams, W.W. Procedures that enhance the maintenance and generalization of induced behavioral change.

York, R. Selected bibliography related to parents as behavioral modifiers.

Haring, N.G. Human Resources.

Haring, N.G. Curriculum development for the severely and profoundly retarded. Using the developmental approach as a basis for planning and sequencing different kinds of curricula for severely/profoundly handicapped persons.

Gast, D.L. Directory of persons involved or interested in the preparation of personnel for severely/profoundly handicapped students. Sept. 1977.

Sailor, W. The TARC System: Instructional objectives for the severely handicapped.

Experimental Education Unit, College of Education and Child Development and Mental Retardation Unit, Univ. of Washington. Uniform performance assessment system (UPAS).

$2 per copy

Region 9, Task Group on Nonbiased Assessment. A position statement on non-biased assessment of culturally different children. Nov. 1976.

$3.10 per copy

Westling, D. & Murden, I. Self-help skills development: An annotated bibliography of operant studies.

Wehman, P., Marchant, J., Williams, B., Briggs, N. & Williams, R. Annotated bibliography and resources related to play, recreation, and leisure skills.

AAESPH Review

Back Issues

Limited numbers of back issues are available as noted below. You may also order a copy of any article which has appeared in AAESPH Review for $ 1 00 each This includes articles from issues which are out of print.

Publication was bi-monthly from September, 1975, to November, 1976 (Volume 1). Beginning with Volume 2 (1977) publication is quarterly.

Volume 1

Number 1, September, 1975 Out of Print

Bailey, C. Curriculum guidelines for teaching profound and severely retarded students (I.Q. under 40) including those with physical handicaps.

Levy, S.M. Development of work skill training procedures for the assembly of printed circuit boards by the severely handicapped.

Pomerantz, D.J. Manual Skill training of retarded children.

Saunders, R., & Koplik, K. A multi-purpose data sheet for recording and graphing in the classroom.

Somerton, E. A selected annotated bibliography in specific subject areas.

Williams, W., Brown, L., & Certo, N. Basic components of instructional programs for severely handicapped students.

Number 2, November, 1975 Out of Print

Model center programs and telecommunications projects for the severely handicapped, Part 1.

Sailor, W. The TARC system: Instructional objectives for the severely handicapped.

Number 3, January, 1976 $2 per copy

Stainback, Susan, and Stainback, William. Teaching the profoundly handicapped in the public school setting: Some considerations.

Ramberg, Joanne, Guess, Doug, and Sailor, Wayne. Training generalized functional acquisition of "yes" and "no" in three retarded children.

Skarnulis, Ed. Less restrictive alternatives in residential services.

Haring, Norris G. Welcome address. Presented to the second annual meeting of the American Association for the Education of the Severely/Profoundly Handicapped.

Sontag, Ed. Zero exclusion: Rhetoric no longer. Paper presented at the second annual meeting of the American Association for the Education of the Severely/Profoundly Handicapped.

Huston, Melinda. Catalogs of special equipment.

Utley, Bonnie. Bibliography for prosthetic and adapted equipment.

Martin, Edwin W. On education for the severely/profoundly handicapped and Justice Douglas. Paper presented at the second annual meeting of the American Association for the Education of the Severely/Profoundly Handicapped.

Steffes, Mike, ed. Bibliography of AAESPH publications.

Number 4, March, 1976 Out of Print

Lynch, Valerie, Shoemaker, Sue, and White, Owen. Training needs survey.

Bellamy, G. Thomas and Snyder, Stephanie. The trainee performance sample: Toward the prediction of habilitation costs for severely handicapped adults.

Reavis, H. Kenton, Morrey, James G., and Hamel, Karin. Behavioral assessment procedures for community re-integration.

Staff of the Diagnostic School for Neurologically Handicapped Children, Southern California, Donald I. Ashurst, Superintendent. Annotated bibliography for professionals and parents who work with severely handicapped children.

Rutherford, Robert B., Jr. Bibliography of books in behavior modification and behavior therapy.

Number 5, May, 1976 $2 per copy

Justen, Joseph E., III. Who are the severely handicapped/: A problem in definition.

Liberty, Kathleen. Data dilemma: Response and measurement units for teachers of the severely handicapped.

Rusch, Frank R., and Close, Daniel W. Overcorrection: A procedural evaluation.

Friedl, Michael. Supplement to: A selected bibliography (partially annotated) related to the vocational training of severely handicapped persons.

Neel, Richard S., and Feder, Marsha. Autism: An annotated bibliography.

Number 6, July, 1976 $4 per copy

Human Resources Guide (A list of professionals willing to share information with others about educating severely/profoundly handicapped persons. It includes areas of expertise and brief descriptions of each individual's current involvement.

Number 7, September, 1976 — $4 per copy

Hunter, Janis D., and Bellamy, G. Thomas. Cable harness construction for severely retarded adults: A demonstration of training technique.

Spooner, Fred, and Hendrickson, Bob. Acquisition of complex assembly skills through the use of systematic training procedures: Involving profoundly retarded adults.

Stainback, Susan, Healy, Harriet, Stainback, William, and Healy, James. Teaching basic eating skills.

Hanson, Marci J. Evaluation of training procedures used in a parent-implemented intervention program for Down's syndrome infants.

Firling, Janice D. Functional language for a severely handicapped child: A case study.

Kotkin, Ronald, and Simpson, Steve. A sign in the right direction: Language development for the non-verbal child.

McCrea, Dennis, Beck, Robin, and Edgar, Eugene. A model for medical/educational assessment of handicapped children in rural and remote areas: American Samoa.

Number 8, November, 1976 — $4 per copy

Burke, Philip J. The determination of adequacy--our Gethsemane? (An essay shared with friends.)

Robinson, Cordelia C. Application of Piagetian Sensorimotor Concepts to assessment and curriculum for severely handicapped children.

York, Robert, Williams, Wes, and Brown, Pansy. Teacher modeling and student imitation: An instructional procedure and teacher competency.

DuBose, Rebecca F. Screening severely handicapped children: The development activities screening inventory.

Schmidt, Paula. Feeding assessment and therapy for the neurologically impaired.

Volume 2

Number 1, March, 1977 — $4 per copy

Edgar, Eugene. Editorial

Haring, Norris G. From promise to reality.

Justen, Joseph E. III, and Brown, Gregory E. Definitions of severely handicapped: A survey of state departments of education.

Neufeld, G.R. Deinstitutionalization procedures.

Wehman, Paul, Renzaglia, Adelle and Schutz, Richard. Behavioral training strategies in sheltered workshops for the severely developmentally disabled.

Mithaug, Dennis E. and Hanawalt, David A. Employing negative reinforcement to establish and transfer control of a severely retarded and aggressive nineteen year old girl.

Elder, Jean K., Pellow, Mary L. and Jipson-Greenstein, Janice. A direction for the future: AAESPH's role in S-3 Materials Accession Process.

AAESPH Review Index to Titles and Authors Volume 1, Numbers 1 to 8; September, 1975, to November, 1976.

Number 2, June, 1977 — $4 per copy

Sailor, Wayne and Haring, Norris G. Some current directions in education of the severely/multiply handicapped.

Mithaug, Dennis E., Hagmeier, Lee D. and Haring, Norris G. The relationship between training activities and job placement in vocational education of the severely and profoundly handicapped.

Hopper, Christine and Helmick, Richard. Nonverbal communication and the severely handicapped: Some considerations.

Burney, James D., Russell, Barbara and Shores, Richard E. Developing social responses in two profoundly retarded children.

Number 3, September, 1977 — $4 per copy

Kissel, Robert C. and Whitman, Thomas L. An examination of the direct and generalized effects of a play-training and over-correction procedure upon the self-stimulatory behavior of a profoundly retarded boy.

Gage, Mary Ann, Fredericks, H.D., Baldwin, Victor L., Moore, William G. and Grove, David. An alternative pattern of educational/residential care and services for mentally retarded children.

Newman, Rebecca, Whorton, Debra and Simpson, Richard. The modification of self-stimulatory verbalizations in a an autistic child through the use of an overcorrection procedure.

Delaney, Sam, and Hayden, Alice. Fetal alcohol syndrome: A review.

Entrikin, Diane, York, Robert and Brown, Lou. Teaching trainable level multiply handicapped students to use picture cues, context cues, and initial consonant sounds to determine the labels of unknown words.

Number 4, December, 1977 $4 per copy

Brown, Lou, Wilcox, Barbara, Sontag, Edward, Vincent, Betty, Dodd, Nancy, and Grueneweld, Lee. Toward the realization of the least restrictive educational environments for severely handicapped students.

Shane, Howard C., Reynolds, Anne T., and Geary, Diane. The elicitation of latent oral communicative potential in a severely handicapped adult: Procedures and implications.

McCormack, James E., and Audette, Robert H. Developing twenty-four hour service plans for severely handicapped learners.

Bates, Paul. Community transition: A behavioral approach with the severely/profoundly retarded and their families.

Knapczyk, Dennis R., and Dever, Richard B. Instructional problem-solving in programming for the severely handicapped.

Venn, John J., Dubose, Rebecca F., and Merbler, John B. Parent and teacher expectations for the adult lives of their severely and profoundly handicapped children.

Reavis, H. Kenton, Hamel, Karin, and Morrey, James G. SEVTC assessment scales for community integration: Development and validation of the post-entry scales.

Volume 3

Number 1, March, 1978 $4 per copy

Johnson, Janice L. Programming for early motor responses within the classroom.

Kahn, James V. Acceleration of object permanence with severely and profoundly retarded children.

Wolery, Mark R. Self-stimulatory behavior as a basis for devising reinforcers.

Allen, K. Eileen. Early intervention for young severely and profoundly handicapped children: The preschool imperative.

Billingsley, Felix F., and Neafsey, Shonah S. Curriculum/training guides: A survey of content and evaluation procedures.

Available from:

American Association for the Education of the Severely and Profoundly Handicapped
(AAESPH)
1600 West Armory Way
Seattle, Washington 98119

REFERENCE MATERIALS

Behavioral Characteristics Progression Booklet. Santa Cruz County Office of Education, Santa Cruz, California 95060.

Case Managers Handbook. St. Louis State School-Hospital. January, 1977.

A Collection of Games and Activities for the Mentally Retarded Child. Henry Datelle.

Curriculum Development for the Teachers of Trainable Mentally Handicapped. State Department of Public Instruction, June, 1969.

Curriculum Guide for Teachers of Trainable Mentally Retarded Children. Division for Exceptional Children, State Department of Public Instruction, Raleigh, North Carolina.

The Diagnosis and Remediation of Psycholinguistic Disabilities. Samuel A. Kirk. Institute for Research on Exceptional Children, University of Illinois, 1966.

Directory of Services for the Handicapped in the Greater Tucson Area. Researched and prepared by Special Education 204 students, Spring, 1978.

An Experimental Curriculum for Young Mentally Retarded Children. Frances P. Connor & Mabel E. Talbot. Bureau of Publications. Teachers College, Columbia University, New York, 1964.

Fostering Growth in Language Skills and Social Concepts. Jean H. Orost. Macmillan Publishing Co., Inc., 866 Third Avenue, New York, New York 10022, 1970. Volume 3.

Fostering Growth in Perceptual and Organizing Skills. Jean H. Orost. Macmillan Publishing Co., Inc., 866 Third Avenue, New York, New York 10022, 1970. Volume 1.

Guide to Early Developmental Training. Wabash Center for the Mentally Retarded. Allyn and Bacon, Inc., 470 Atlantic Ave., Boston, Massachusetts., 02210. Revised printing, 1972.

A Motor Perceptual Developmental Handbook of Activities for Schools, Parents, and Pre-School Programs. Frank A. Belgau, Vision Development Guidance Clinic, University of Houston, College of Optometry, P.O. Box 936, La Porte, Texas 77571.

New Mexico State Curriculum Guide. Jane Blumenfeld & Pearl E. Thompson. March, 1970.

PEDaT: Strategies for Training the Severely and Profoundly Handicapped Child. W. John Shrader, Logansport Area Joint Special Education Cooperative, Logansport, Indiana; Thomas E. Pomeranze, Huntington County Association for Retarded Citizens, Huntington, Indiana; Joseph W. Kunz, Superintendent, St. Louis State School Hospital, St. Louis, Missouri; Thomas Templeton, Director of Special Education, Indianapolis Public Schools, Indianapolis, Indiana.

Philosophy for the Education of the Mentally Retarded Child in the Tucson Public Schools.

Play Environment for Children, Play Space, Improvised Equipment, and Facilities. Margaret H. Aitken. Educational Designs and Consultants, 3259 North Shore Road, Bellingham, Washington.

Radea Sample Materials. Melton Book Company, 111 Leslie Street, Dallas, Texas 75207.

Severe/Profound Handicapped Children: An Integrated Activity System for Hand Function and Language. Pam Babbitt, Pam Dunbar, Donna Zimmerman, Esperanza Para Nuestros Ninos, A Program for Severe/Profound Handicapped Children, P.O. Box 12212, Albuquerque, New Mexico 87105, September, 1976.

Special Education Curriculum Guide. Paradise Valley Schools.

TMR - Objective Task Rating Scale. Clark County School District, Helen J. Stewart School, 2375 E. Viking Ave., Las Vegas, Nevada 89109.

Trainable Children - Curriculum and Procedures. Julia S. Molloy. The John Day Company, New York.

4. CLASSROOM

Classrooms for all children should provide a conducive environment for learning; they should provide adequate space for the children, the teacher and aides; they should be arranged to facilitate use of the equipment, supplies and materials that will be utilized by the teaching team and students. When the classroom houses severely handicapped students, meeting these needs challenges the administrative skills of those who are responsible for providing the physical and environmental setting for students. Each classroom should be viewed as part of the total school building, moreover, and should encourage the easy interaction and integration of the handicapped student with his or her nonhandicapped peers. Such interaction will depend on more than the physical layout of the classroom, however; it will also depend on acceptance of the seriously impaired students by other faculty members, paraprofessionals, and the other students enrolled at the school.

Components	Resources
Physical Design Considerations	See pp. 70-73.
Is facility barrier free? What are physical space needs? Are air conditioning and ventilation adequate? What are lighting requirements? What types of floor covering?	Suggested Guidelines for Local School District Compliance with Section 504 of the Vocational Rehabilitation Act of 1973. "Physical Accessibility Check-list," pp. 19-44 details legal requirements. Includes guidelines for determining required structural changes for existing facilities, and requirements for new buildings. Order from: Arizona Department of Education 1535 West Jefferson Phoenix, Arizona Available in 1979: Access for All: An Illustrated Handbook of Barrier-Free Design. E.A. Ainc and R.D. Loversidge, Jr., eds. Special Press, 724 S.

-continued-

4. CLASSROOM (continued)

Components	Resources
	Roosevelt Ave., Columbus Ohio, 43209. $25.50 prepaid. Also in 1979: *Training Center Design*, Schooley Cornelius Assoc. Special Press (address above). $35.95 prepaid.
Furniture and Equipment	See pp. 74-77.
What will be needed for physical and occupational therapy? What other specialized equipment will be needed?	*How to Build Special Furniture and Equipment for Handicapped Children*, Ruth B. Hoffmann, 1970. Charles C. Thomas, 301-327 E. Lawrence Ave., Springfield, Illinois, 62717. $6.50.
Special Problems	
What extra kinds of personnel and supplies may be needed?	*Nonvocal Communication Techniques and Aids for the Severely Physically Handicapped*, Gregg C. Vanderheiden, ed. University Park Press, 233 E. Redwood St., Baltimore, Maryland, 21202. $12.50.
Fire and Evacuation Procedures	
Does a fire plan exist for the special classroom? What about evacuation procedures? Are fire drills held? What staff need special training?	See pp. 78-80.

4. CLASSROOM (continued)

Components	Resources
Other Staff/Studentbody	
Have other teachers been oriented to the severely handicapped students and the classroom activities?	See p. 81.
What about the other children in the school?	
Other Classroom Resources	
Foster grandparents?	
Student interns?	
Older student tutors?	
Classroom parents?	
Aides?	*An Effective Program for Teacher Aide Training*, John McManama. Parker Publishing Co., Nyack, N.Y. Teacher aide training curriculum developed by Tucson Unified School District.

CLASSROOM

1. General Physical Design Considerations

   A. Facility must be generally barrier-free

      1. Ground floor, if possible.
      2. Wheelchair ramps with railings; doorways to accomodate wheelchairs.
      3. Handrails in hallways and bathrooms.
      4. Toilets, sinks, drinking fountains accessible to students.

   B. Physical space and classroom layout

      1. Classroom size recommended: 900 sq. ft. for a maximum of 15 children.
      2. Movable partitions, shelves or cabinets to provide space for various size groups and instructional purposes.
      3. Additional space recommended:
         a. Partitioned observation and/or individual tutoring area.
         b. Bathroom and changing room.
         c. Office space for teacher and therapists.

   C. Air conditioning and ventilation

      1. Temperature control.
      2. Extra exhaust fans to aid ventilation.

   D. Lighting

      1. Natural light from windows.
      2. Artificial lighting, rheostat-controlled.

   E. Flooring

      1. Carpeted areas
         a. Physical therapy.
         b. Training areas.
         c. Small group and individual instruction areas.
      2. Tiled areas
         a. Room entrance and a way through the room with wheelchairs.
         b. Bathroom and changing area.

II. Furniture and Equipment

A. Physical/occupational therapy (i.e. mats, wedges, prone boards, side lyers, floor sitters).

B. Speech/language and communication devices; adaptive feeding equipment.

C. Storage cupboards, closets, shelves.

D. Tables and chairs, child and adult size.

E. Classroom supplies and materials.

F. Appliances

1. Washer/dryer (if laundry service is not used).
2. Refrigerator, for snacks, juice, etc.

G. Audio-visual equipment.

III. Special Problems to be Considered

A. Cleaning and maintenance: extra personnel and supplies may be needed.

B. Laundry needs

1. Towels and washcloths.
2. Disposable diapers.

C. Room odor: prevention by:

1. Toilet training.
2. Frequent checks and diaper changing.
3. Adequate ventilation and exhaust fans.
4. Air deodorizers.

Arizona Department of Health Services
Bureau of Child Development

Project CHAIN: Characteristics of the Physical Environment

Even though class size is small, the availability of a full, standard-sized classroom is essential. This permits the establishment of separate areas for quiet and noisy activities, group and individual programs.

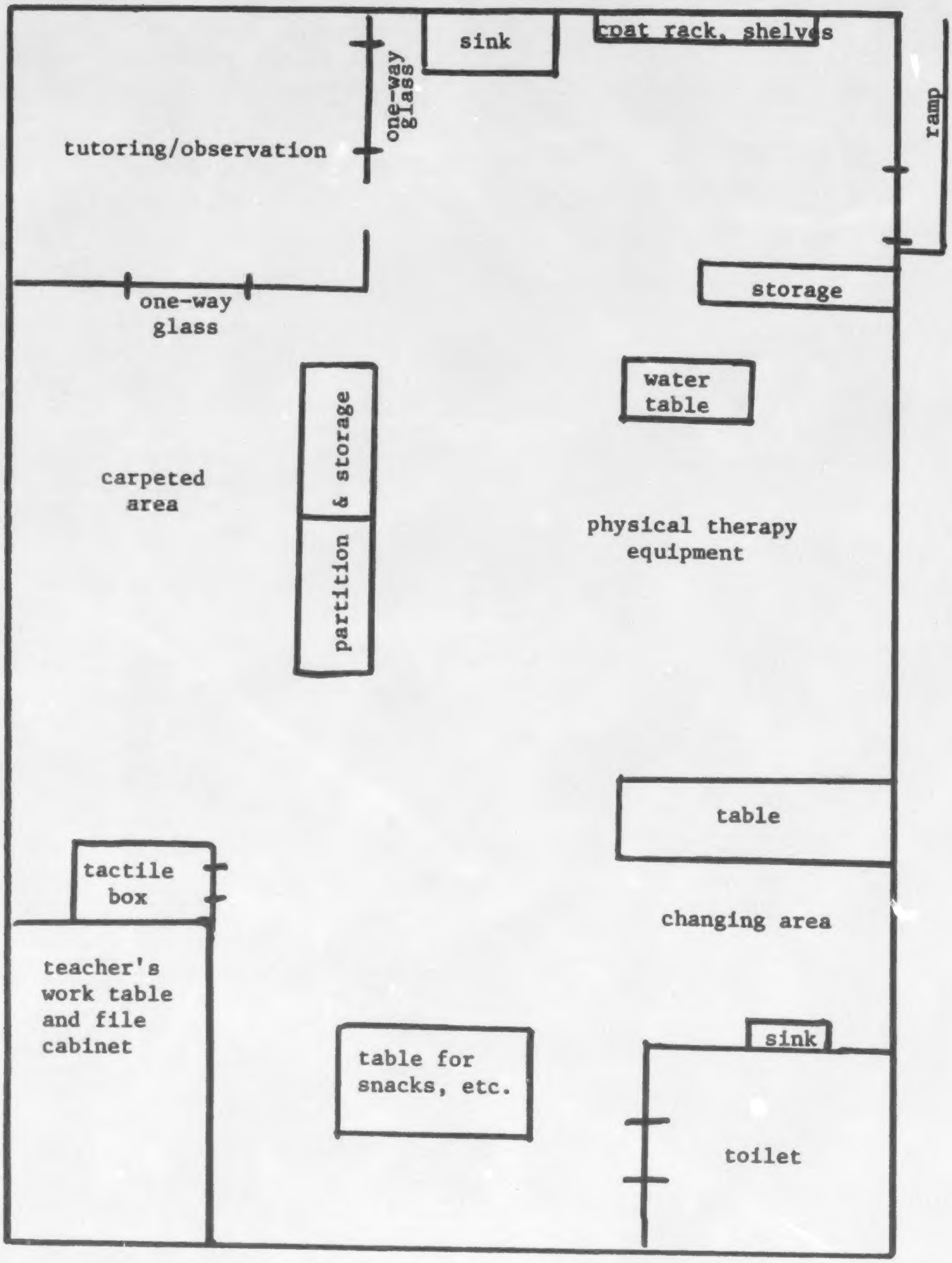
When the demonstration classroom acquired its present space, two major alterations were required. There were no toilet facilities in or immediately adjacent to the classroom. A bathroom was constructed in the classroom and equipped with a child-sized toilet. The small toilet was considered to be essential for toilet training with primary-age children. Immediately adjacent to the bathroom, a sink was installed and an area for changing diapers and clothing was provided.

The second major alteration was the partitioning of one corner of the classroom to provide individual tutoring and observation facilities. This area has two one-way observation areas, rheostat-controlled lighting, and a ventilating fan. Space such as this which permits delivery of programs under maximally stimulus-controlled conditions is felt to be essential.

The remaining classroom area is further divided by movable, waist-high partitions which also provide storage for toys and materials. One area is covered with a rug, and is used for quieter group and individual activities. The uncarpeted area is used for messy activities (water play, painting) and for physical therapy activities requiring a mat and/or large equipment. This use of the partition helps to reduce the visual distraction for children engaged simultaneously in two kinds of activities. At the same time, the height of the partition enables the teacher to check on activities in all parts of the classroom except the tutoring room.

One minor structural modification was also required. The classroom is housed in an older school building, and there was originally a step up to the classroom door. This step had to be replaced by a ramp and enclosed with a railing.

4. CLASS.



sink
coat rack, shelves
one-way glass
tutoring/observation
ramp
one-way glass
storage
water table
partition & storage
carpeted area
physical therapy equipment
table
changing area
tactile box
teacher's work table and file cabinet
table for snacks, etc.
sink
toilet

Project CHAIN : Types of Materials and Equipment Used in the Demonstration Classroom

prone boards
adapted scooter board
corner chair
adapted toddler chair
Mancino Developmental Crawler
Mancino Learning System Chair
mats
barrel
walker
bean bag chair
wedges
vestibular board
spot trainer
record player & records
communication board (pictures)
large beach balls
rhythm band
mobiles and cradle gyms
activity center busy box
tops, pound-a-round
dolls
pegboard
teethers
rattles
rubber squeak toys
paint
crayons
marking pens
picture books
easel (table top)
tactile stimulation box
sand/water table
water toys
mirrors
noninterlocking puzzles
bells
flashlight, penlight
vibrators (battery)
balls
refrigerator
pull toys
wind-up toys
hand puppets
disposable diapers
adaptive feeding equipment
wading pool
side lyer
individual and group tables
file cabinet
closed storage cabinet
linen (wash cloths, towels)
rocking boat
battery charger
sandbags
bolsters and rolls
paint aprons
prone board straps
tumble-back toys
blocks (wood and plastic)
bristle blocks
pounding toys
large-size clothing
net hammock/swing
baby food
teething biscuits

Resources/Catalogs for
Classroom Supplies and Materials for Special Education

"Toys That Teach," "The Growing Years Catalog,"
"For Children With Special Needs"
Childcraft Education Corporation
20 Kilmer Road
Edison, New Jersey 08117
(800) 631-5657

Constructive Playthings
12373 Garden Grove Blvd.
Garden Grove, CA 92643
(714) 636-7831

Developmental Learning Materials
7440 Natchez Avenue
Niles, Illinois 60648
(312) 647-7800

Educational Teaching Aids
159 W. Kinzie Street
Chicago, Illinois 60610

"Catalog of Play, Learning and Growth"
Kaplan School Supply Corporation
600 Jamestown Road
Winston-Salem, NC 27103

Lakeshore Curriculum Materials Co.
16463 Phoebe St.
La Mirada, CA 90637
(213) 921-7468

"Nasco Learning Fun"
NASCP
P.O. Box 3837
1524 Princeton Ave.
Modesto, CA 95352

Teaching Resources Corporation
100 Boylston Street
Boston, Massachusetts 01226

Teaching Tools
P.O. Box 27567
Phoenix, Arizona 85061
(602) 272-7973

Resources/Catalogs for Special Equipment and Furniture

Abbey Rents and Sells
724 W. Indian School Road
Phoenix, Arizona 85013
(602) 277-5744

"Achievement Products for Children"
Achievement Products, Inc.
P.O. Box 547
Mineola, New York 11501
(516) 747-8899

Community Playthings
Rifton
New York 12471
(914) 658-3142

"Preston Special Education Materials"
J.A. Preston Corporation
71 Fifth Avenue
New York, NY 10003
(800) 221-2425

"Be OK Self-Help Aids"
Fred Sammons, Inc.
Box 32
Brookfield, Illinois 60513
(312) 246-3216

"S.D.E. Equipment for Children and Adults"
Skill Development Equipment Co.
Box 6300 1340 North Jefferson
Anaheim, CA 92807
(714) 524-8750

Western Medical Supply Company
2040 N. 16th Street
Phoenix, Arizona 85006
(602) 257-9347

RESOURCES FOR ADAPTIVE EQUIPMENT

In Arizona several agencies/programs are involved with the purchasing of adaptive equipment, yet there is no one agency/program that is clearly responsible. P.L. 94-142 requires school districts to provide "Related Services" (121a.13), but there is often a question as to whether specialized adaptive equipment is a "supportive service which is required to assist a handicapped child to benefit from special education." Typically, what occurs is that professionals who work with a particular student and the parents recognize a need for adaptive equipment but, due to financial limitations and restrictions, the equipment is difficult to locate and/or purchase and therefore arguments ensue regarding "What organization is responsible?" If a situation arises for a need for adaptive equipment, the following might be used as possible resources for the equipment (listed in no particular order):

SCHOOL DISTRICTS	Within the school district's budget might be dollars for adaptive equipment. For students who are placed in school districts from Arizona Training Programs, the school district is eligible for funds from 89-313 (Title I). For FY79 this amounted to approximately $500 per student. This money is designated to support educational programs for these students.
DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION	In some areas of the state the Division of DD/MR has staff or contracted services which might be available to build or help design adaptive equipment.
STATE DEPARTMENT OF EDUCATION	Contact the SDE for information regarding the building of equipment by Fort Grant.
FOSTER CARE	If a student is a foster child, the Comprehensive Medical and Dental coverage will pay for equipment, if prescribed by the physician.
OTHER RESOURCES TO CONTACT	Crippled Children's Hospital Easter Seals Shriners Optimists Lions organization Sun City (has built equipment)

FIRE AND EVACUATION PROCEDURES

Introduction

Schools in which special education classes are located should already have Fire Plans approved by the local fire department for the entire school. The existing plan and procedures should be reviewed and revised as necessary to take into account any special procedures required to safely evacuate handicapped children.

Many of the following elements will already be a part of the school's Fire and Evacuation Plan, while others may need to be added. The school administrator, special education teacher and chief of the local fire department should work together in planning and implementing special considerations based on particular needs of each student.

Checklist: Elements of Fire and Evacuation Procedures

I. Fire Plan

- A. What to do when fire or smoke is detected.
- B. Responsibilities of various staff members in the school.

II. Evacuation Plan

- A. Two planned exits for each room (one regular and one emergency).
- B. Diagram of exits and their use is posted conspicuously.
- C. Alarm codes; special codes may be used to denote location of the fire on the campus.
- D. Procedures for transporting students:
    1. Nonambulatory students: use of fire blankets, wheelchairs, special carries, or other devices.
    2. Ambulatory students: procedures to assure their safe and orderly exit from the building.
    3. Training of additional personnel needed to transport students.
- E. Duties and responsibilities of person in charge of the evacuation.
- F. Staff members in the school who are not directly responsible for classes (i.e. maintenance, cafeteria, office, nursing) could be assigned to assist in evacuating special education classes. Duties and responsibilities should be outlined in the plan.

III. Fire and Evacuation Drills

A. Drills should be conducted at least monthly.

B. Records should be kept on each drill.

1. Date and time.
2. How long did it take to evacuate the area.
3. Response of students and staff (were procedures followed correctly).
4. Recommendations for improvement.

IV. Staff Training

A. One person should be designated to train staff in the Fire and Evacuation Plan and Procedures for the special education classes.

B. All staff members involved in evacuation should attend a training session at the beginning of each semester.

C. Both demonstration and a written test should be required of every involved staff member.

MONTHLY FIRE DRILL SCHEDULE *

A fire drill should be held at least once a month and recorded. Vary the time of day, location and exit plans. Specific comments on each drill should also be recorded.

January

date ______________________________

time: begins ______________ ends ________

location ______________________________

comments ______________________________

____

____

February

date ______________________________

time: begins ______________ ends ________

location ______________________________

comments ______________________________

____

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March

date ______________________________

time: begins ______________ ends ________

location ______________________________

comments ______________________________

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* From Operating Manual for Residential Services Personnel, 1974 F. Holland, and R. F. Rubeck, eds. Nisonger Center for Mental Retardation and Developmental Disabilities.

Project CHAIN: General Considerations in Establishing a Classroom for Severely Handicapped Students in a Regular Elementary School

1. If children will be coming from more than one school district, it is essential that sponsoring districts be kept informed of the program and of the individual child's progress. Directors of Special Education and other appropriate personnel should be invited (encouraged) to visit the program.

2. Program staff should not provide transportation for children. This too severely restricts planning and organizational time for staff. Sponsoring school districts should assume responsibility for transporting children to and from the program.

3. All teaching staff in the school should be oriented to the program, including characteristics of children served and instructional approaches. A slide presentation at a regular faculty meeting has been found to be an effective way to do this.

4. Orientation of upper grade students (grades 5, 6, 7, and 8 especially) similar to that provided for teachers is helpful in gaining acceptance of the children in school. Scheduling times when students and teachers can observe the program is also helpful.

5. With severely multiply handicapped children account must be taken of the fact that some of the children may be subject to medical crises. The school nurse must be informed of kinds of crises which may arise. In addition, preliminary arrangements must be made, such as signed permission from parents to transport children immediately to the nearest hospital. This is not generally permitted for schools and must be cleared in advance by parental signature.

6. Classroom staff should be trained by the physical therapist to do postural drainage with percussion and vibration. In addition, if there is any likelihood that it might be needed, suction equipment should be available and classroom staff trained in its use. School nurses are often responsible for more than one school and might not be available in an emergency.

7. Insofar as possible, the teaching staff should adhere to the schedules of the regular teaching faculty, including lunch and break schedules and locations. Also, the teacher should plan to participate in regular staff activities such as faculty meetings.

5. MEALTIMES

There are several major concerns associated with mealtimes for severely and profoundly handicapped children and youth in the public schools. The concerns are:

1. What foods are necessary to provide the appropriate nutrients for optimal growth and development?
2. How should the foods be presented - temperature, texture and adaptive feeding techniques - to facilitate development of oral skills and inhibit abnormal oral behaviors?
3. What adaptive devices could be utilized so that the child could gain a degree of independence by feeding himself?
4. How can possible later speech development be facilitated by teaching normal eating skills to enhance oral control?

Strategies for answering these questions require cooperation of all of the people involved with the child, including teachers, parents, nutritionists and therapists.

Components	Resources
General Sanitary Considerations	
What are the regulations concerning storage, preparation and serving of food in the school setting?	See pp. 86-96 for Arizona Department of Health Services, Bureau of Child Development: "Feeding Techniques for the Handicapped."
What are the requirements for special equipment and supplies needed to store, prepare or serve food?	
What will be the sanitation procedures for the personnel, equipment and supplies as outlined in the above regulations?	

5. Mealtimes (continued)

Components	Resources
Dietary Requirements	
Does the child have any food allergies?	See student's IEP, IPP; contact student's parents, medical doctor.
Is the child's diet nutritionally unbalanced because of food dislikes?	For children who are DD/MR group home residents, ask home manager; for other children, contact the Bureau of Nutrition, Arizona Department of Health Services.
Do some of the child's medications cause certain nutrients to be discarded by the body rather than absorbed?	
Can snacks and lunches at school be used to introduce new foods?	
Would certain nutritional supplements be helpful for increasing calories or adding nutrients?	
Does food preparation require special equipment in the classroom or lunchroom?	
Can a child participate in the school lunch program by receiving free lunches, reduced payment or full payment?	
Do quantities or types of fluids or foods consumed need to be recorded?	
Presentation of Food	
What position(s) will facilitate appropriate eating skills in the child?	See pp. 86-96 for Arizona Department of Health Services, Bureau of Child Development: "Feeding Techniques for the Handicapped."
What textures of foods are acceptable to the child and encourage appropriate eating skills?	

5. Mealtimes (continued)

Components	Resources
Presentation of Food (continued)	
What adaptive feeding techniques and equipment can the feeders use and where will they learn them? What steps can be taken to ensure cooperation between the home and school in carrying out therapeutic feeding programs?	*Program Guidelines for Children with Feeding Problems*, by Suzanne Evans-Morris, Ph.D., Childcraft Education Corp. 20 Kilmer Road, Edison, N.J., 00817. $5.95 plus postage. *Mealtimes for Severely and Profoundly Handicapped Persons*, by Robert Perske, University Park Press, 233 E. Redwood St., Baltimore, Md., 21202. $7.95 plus $1.40 postage.
Acquisition of Self-Feeding Skills	
What prerequisite oral and motor skills must the child have before he can learn to feed himself?	*Developing Effective Individualized Education Programs for Severely Handicapped Children and Youth*, Norris G. Haring, ed. "Daily Living Skills" by Philippa H. Campbell, pp. 115-138. Special Press, 724 So. Roosevelt, Columbus, Ohio, 42309. $11.45 prepaid.
What specialized, adaptive feeding utensils and/or seating devices could be used by the child to assist him in feeding himself?	"Be OK Self-Help Aids" Catalog, Fred Sammons, Inc., Box 32, Brookfield, Ill., 60513.

5. Mealtimes (continued)

Components	Resources
Eating and Oral Skill Development as Prerequisites to Later Speech Development	
Has the speech pathologist reviewed the feeding program to make suggestions for incorporating sound production at eating times (especially snack times)?	School Speech Pathologist

ARIZONA DEPARTMENT OF HEALTH SERVICES

BUREAU OF CHILD DEVELOPMENT

Feeding Techniques for the Handicapped

After reading this packet, you should be able to discuss the topics listed below. You will learn best if you carefully read the objectives and remember them as you read the text. Review them before you meet with the instructor. For this last review, remember that you have learned the necessary information if you can answer questions about the objectives listed below. If you have any questions, ask the instructor before you take the written examination.

The following is a list of questions you should be able to answer in your own words upon completion:

1. When should your hands be washed during feeding?
2. When should the client's face and hands be washed?
3. How do you test the temperature of the client's food?
4. How much fluid must a client receive at scheduled drink times?
5. When should you temporarily stop feeding a client during his meal?
6. Why must clients with little physical control have a stable base for feeding?
7. Why is it important for the client to be positioned symmetrically?
8. Why is it important for the client to sit upright?
9. Why is it important for the client's feet to be positioned on a solid platform?
10. In what direction should the food be brought to the client's mouth?
11. Why should a client receive jaw control?
12. How is jaw control given to the client?
13. What precautions should you take in giving jaw control?
14. Why should a client receive "downward pressure on the tongue?"

15. How do you give "downward pressure on the tongue?"

16. Where should the table be positioned when a client is learning to self-feed?

17. When should a client be given assistance in self-feeding?

18. How should a client's affected arm be positioned during self-feeding?

19. How can you best assist a client if he needs a lot of help in self-feeding?

20. Why is it important to give the client minimal help when he is learning to self-feed?

21. If problems persist in a client's feeding program, who should you contact?

Feeding Techniques for the Handicapped

Objectives

Handicapped children and adults must eat for the same reason anyone does: to provide the body with the essentials for growth. Eating for many handicapped individuals is made difficult because of their abnormal movement problems and expecially their lack of oral motor control. Many factors must be considered:

1. Overall health and hygiene
2. Body positioning
3. Movement of oral structures during the process of eating
4. Oral sensation

This packet will discuss normal patterns of eating, correct hygiene procedures, and some suggestions for the use of adaptive feeding techniques.

PART I: Health and Hygiene

Preparation before, during, and after eating is necessary to help prevent the spread of illness from one client to another as well as from the staff to the clients. In addition, there are accreditation, county, state, and federal health laws which list standards for the cleaning of clients, staff, tabletops, eating utensils, and other equipment.

Always wash the client's face and hands before feeding to prevent getting dirt or germs in his food, and after the meal to prevent food or liquid from drying on his skin. Always wash your own hands prior to feeding each client to prevent the spread of dirt or germs to the food or directly to the client. Be sure to wash your hands prior to feeding a second client so that germs cannot be transported from one client to another. Your hands must also be washed after feeding is completed.

You must avoid burning the client's mouth with food that is too hot for him. Test the temperature by stirring one compartment of food and drop a small amount of food from the spoon to the inside of your wrist. If the temperature of the food is uncomfortable to your wrist, it is definitely too hot for the client's mouth. Set the tray aside until the food has cooled.

It is very important that clients receive enough fluids into their system to prevent dehydration(loss of too much fluid from the body). At each meal time and other scheduled drink times, each client weighing under 30 pounds should receive at least six ounces of fluid.

Each client weighing over 30 pounds should receive a least eight ounces of fluid. If a client does not have good oral control and loses a lot of fluid while drinking, always be sure to make up for this loss of fluid by offering him more.

During mealtimes or scheduled drink times, there are two major health reasons for temporarily ceasing giving the client food or fluid. If he has a seizure, he may not be aware of food in his mouth and is in danger of aspirating (breathing the food into his lungs). When a client has a seizure, discontinue feeding him until the seizure is over. After the seizure, you may continue his meal if you feel he still wishes to eat. If a client vomits while eating, it is usually due to some health problem and he should be checked by medical personnel. Notify the nurse and do not continue the meal, unless you are instructed otherwise.

PART II: Correct Positioning

Correct positioning during feeding is more essential for clients with movement problems than for everyone else. If they do not have a stable, controlled base for sitting, it is difficult for them to control trunk, head, lips, cheeks, and tongue. In addition, if the head is in improper relationship to the body, the entire eating process of taking the food in, chewing, and swallowing is made more difficult or impossible.

Body Position

It is important to determine where and how a handicapped client should sit during mealtimes. The following conditions should be met:

I. Positioning is as symmetrical as possible with the handicapped client's head in the midline, and arms and legs controlled and toward the center of the body.

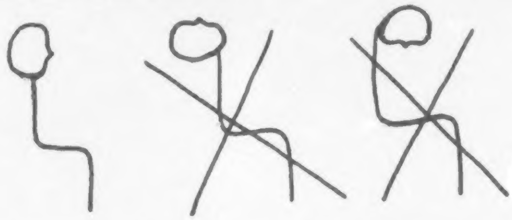
Reason: Symmetrical positioning assists in inhibiting the expression of primitive reflexes which allow only reflexive movements rather than voluntary, controlled movements.

2. Positioning is as upright as possible with handicapped client's head sitting squarely on top of spine and hips bent at a 90° angle.

Reason: When a handicapped client reclines and food is put in his mouth, the food tends to slide to the back of the mouth and slide down the throat, possibly causing him to aspirate (breath food into his lungs).

3. Positioning allows (or forces) head to be in correct front-to-back alignment with spine.

Reason: If the head is hung or pushed back, it is nearly impossible to close lips, chew food, or swallow properly. If the head is hung forward, it is very difficult to get the food in, to keep the food in his/her mouth, to mix it with saliva, and to swallow.



4. Positioning allows the client's feeder to give adequate external control to the oral mechanism.

Reason: Some clients are not able to control their own oral mechanisms, so it is the feeder's responsibility to provide external control.

5. Positioning provides stability and support of arms and legs with feet resting solidly on foot supports or on the floor with knees and ankles bent at a 90° angle (or as close as the client's deformities will allow) and the arms resting or restrained in a still position.

Reason: If the feet and arms have a solid base, the client will not have to be concerned with controlling excess movement in the legs and can concentrate instead on controlling the mouth in eating properly.

Some possible suggestions:

a. In a beanbag chair
b. In "regular" chair that is adapted to enforce the positions mentioned above
c. In a feeder's lap, if the client is small enough to be controlled as described above.

PART III: Normal Eating

It is important to examine the way children and adults normally eat. By the time children are three, they have generally mastered all the skills of eating that adults have. For many handicapped clients, we strive to encourage them to eat in a normal fashion, as adults do. The following are descriptions of normal eating of various types of food.

Eating From a Spoon

In eating food from a spoon, the following sequence occurs:

1. Mouth opens, with tongue resting on the floor of the mouth
2. Spoon is put in the mouth
3. Mouth and lips close on the spoon
4. Spoon is removed from the mouth as closed lips remove food from spoon
5. Tongue transfers food to one or both sides to be chewed
6. Food is chewed; tongue is constantly repositioning the food so that is can be effectively chewed
7. When it is felt that the food is chopped enough by the teeth, the food is transferred to the middle of the tongue in preparation for swallowing
8. Swallow occurs with lips closing, tip of tongue going up to ridge behind upper teeth; middle and back of tongue following in a wavelike backward motion
9. Swallow is repeated if residual food is detected in the mouth

Eating Cookies or Crackers

In eating cookies or crackers, the following sequence occurs:

1. Mouth opens with tongue resting on the floor of the mouth
2. Cracker is rested on lower teeth
3. Upper and lower teeth are brought together, biting off piece of cracker which lands on the tongue just behind the lower teeth
4. Tongue transfers food to one or both sides to be chewed
5. Food is chewed; tongue is constantly repositioning the food so that it can be effectively chewed
6. When it is felt that the food is chewed enough by the teeth the food is transferred to the middle of the tongue in preparation for swallowing
7. Swallow occurs with the lips closing, tip of tongue going up to ridge behind upper teeth; middle and back of tongue following in a wavelike backward motion

Drinking Liquid from a Cup

In drinking from a cup, the following sequence occurs:

1. Mouth opens with tongue resting on the floor of the mouth
2. Rim of cup is rested on lower lip
3. Tongue is positioned with tip down behing lower teeth, middle of tongue forms a seal against middle of hard palate
4. Cup is tilted so that the liquid meets tongue in the mouth

5. Liquid is sucked into the mouth by the tongue's downward movement which creates suction
6. Cup is removed when enough liquid is felt in the mouth
7. Lips close as cup is removed
8. Swallow occurs with lips closing, tip of tongue going up to ridge behind upper teeth, middle and back of tongue following in a wavelike backward movement

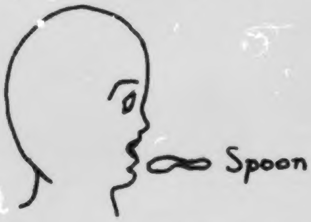
PART IV: Adaptive Feeding Techniques

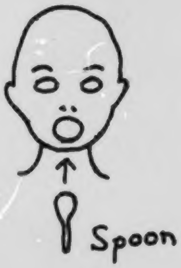
Because of oral sensorimotor problems, many handicapped clients are unable to follow the previously mentioned sequences in eating and drinking. Some of the feeding techniques used by feeders actually discourage the development of these normal sequences. The following adaptive feeding techniques should be used to encourage the handicapped client to develop behaviors listed in the normal feeding sequences.

Proper Presentation of Food

Uses: Many of the handicapped client's bodies "get stuck" in reflex positions, expecially when their heads are turned to the side or tipped too far backward or forward.

Description: Handicapped clients should have food presented when their heads are positioned facing directly forward, even if you have to assist them in doing so. Also, food should be presented from straight ahead and coming from below eye level.



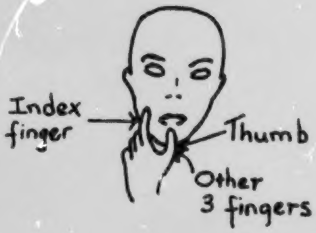


Jaw Control

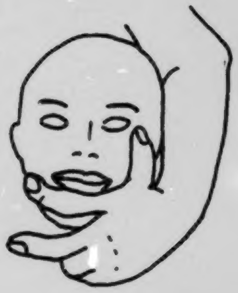
Uses: Jaw control is generally used when it is desirable to have the jaws and/or the lips closed or in closer proximity. Having the jaws closer also makes a smaller area in which the tongue moves and can facilitate better tongue action. Jaw control is useful when:

1. A client has jaw thrust and cannot purposefully close his jaws

2. A client doesn't have a jaw thrust, but opens his mouth too far as he attempts to suck food or liquid from a utensil
3. A client's most common action is tongue thrust. With jaw control, he cannot push it out as far if you are keeping his jaw shut



Description: Jaw control can be given either from the front or from the side. From the front, positioning is done as pictured on the right. Thumb is flat against the chin, just under the lower lip. Thumb can assist in both opening and closing the jaw. Index finger is extended along the jaw line, with the tip of the finger just below the temple. Index finger is used to stabilize the hand against the face. Third, fourth, and fifth fingers are bent horizontally across the width of the underside of the jaw. These fingers give the upward thrust to close the jaw.



From the side, jaw control is done as pictured on the left. Thumb is along the jaw line reaching up toward the temple. Thumb is used to stabilize the hand against the face. Index finger extends horizontally across the front of the chin and can assist in opening and closing the jaw and lower lip. Middle finger extends horizontally across the underside of the jaw and can assist in closing the jaw. Fourth and fifth fingers are curled gently and do not take part in the opening and closing.

CAUTIONS:
1. Giving too much pressure with any of the fingers can be painful to the client.
2. Giving jaw control when the client doesn't need it is wasted effort and may prevent him from making progress.
3. Giving jaw control can put the head out of alignment with the body, unless there is a firm, properly positioned support behind the head.

Jaw control can also be helpful if a client begins to choke during a meal. If he begins to cough and sputter, gently lean him forward or to the side so that excess food can be drained from the mouth. Then, assist him by giving him jaw control so that he can better remove remaining food by swallowing correctly. NEVER place a client who is coughing on his back.

CAUTION: When moving the client forward or to the side, do it very slowly. A sudden movement will cause him to take a quick breath of air which can lead to aspiration of the food or fluid in his mouth. This can be very dangerous.

Downward Pressure on the Tongue

When downward pressure on the tongue is necessary, it is best to use a tongue depressor rather than a spoon as an eating utensil. The rounded bowl of the spoon makes it very difficult to push down, and the sharp metal edge of the spoon makes it uncomfortable, even painful.

Uses: This downward pressure is generally used to help direct the tongue to accomplish a less abnormal movement and/or a more advanced or sophisticated movement. Downward pressure on the tongue is useful when:

1. A client "bunches up" his tongue or thrusts it out when you put food in his mouth
2. A client tongue thrusts in trying to move the food to the back of his mouth to swallow
3. A client tongue thrusts in trying to swallow the food

Description: Scoop the food with the tongue depressor just as you would with a spoon. When the client opens his mouth, or is assisted with jaw control in opening his mouth, the tongue depressor with the food on it is placed on the front 1/3 of the tongue. The pressure is then directed downward, with a slight backward (into the mouth) push, then removed.

PART V: Assistance in Self Feeding

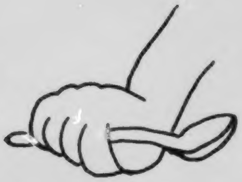
Clients who feed themselves or are learning to feed themselves must be maintained in a normal sitting position so that they have as much control of their arms, legs, and head as possible. Be sure that the client's chair is placed properly at the table so that the table edge is touching the front of the client's body. The table should be positioned at the height of the client's elbow.

CAUTION: Before beginning a self-feeding program with a client, be sure to check with the Speech Pathologist or Occupational Therapist to be certain that he is ready to begin self-feeding in terms of overall oral control. This is VERY important.

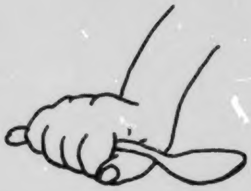
Assistance in self-feeding is useful when:

1. The client has difficulty in maintaining a firm grasp on the spoon handle without his wrist bending down or his thumb getting stuck under his fingers
2. The client cannot correctly scoop the food onto the spoon
3. The client has trouble getting the spoon directly into or out of his mouth
4. The client has difficulty getting the cup to his mouth without spilling liquid

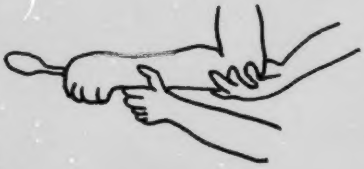
Description: If the client has better control with one arm and hand, ALWAYS let him use his better hand for self-feeding. However, his more affected arm must be positioned properly to better assist him in an overall proper body position. His arm should be extended forward on the tabletop with the palm of his hand placed downward.



If the client grasps the spoon with his thumb caught under his fingers (as shown on the left), have him open his hand. You may have to assist him in opening his hand by grasping his hand below the base of the thumb and gently rotating the thumb outward. Help him to grasp the spoon correctly with his fingers curled downward over the spoon handle and his thumb curved upward from under the spoon handle, resting on the outside of his fingers (as shown on the right). If the client cannot maintain this grasp, place the fingers of your same hand gently over his.



If the client tends to bend his hand downward from the wrist, or has difficulty scooping or directing the food to his mouth, help him by assisting his direction, grasping him at the wrist joint. Use your fingers and thumb to move the wrist slightly up, and your palm to direct the movements of his hand. If further directive help is necessary, use your other hand under his elbow (as shown on the right).



Remember to give the client ONLY as much assistance as he needs. If you give him too much assistance, you are denying him the opportunity to increase his skills in self-feeding.

HINT: If the client is having difficulty in self-feeding, check with the Speech Pathologist or the Occupational Therapist to see if adaptive feeding equipment may be helpful.

These are the most commonly used adaptive feeding techniques. They should be used under the conditions and guidelines suggested above. If you feel that you have used the techniques appropriately and consistently for three days, and no positive effects are noted, get in touch with the Speech Pathologist or Occupational Therapist by writing in the Consultant Communication Book.

Available as loan-copy for duplicating from:

Inservice Training Coordinator
Arizona Department of Health Services
Bureau of Child Development
200 N. Curry Rd.
Tempe, AZ
244-9471, Ext. 244.

Prepared by: Linda Lake, Speech Pathologist
Tammy Cales, BCD In-Service Coordinator
July, 1978

6. TOILET TRAINING

Toilet training has not been considered a traditional area for public school education; with the entry of severely and profoundly handicapped students into the school, however, helping these students develop such self-care skills becomes a critical curriculum area. Most children develop toileting skills spontaneously or with minimal intervention, but severely and profoundly handicapped students need careful and systematic training. The approach must begin with a careful assessment of capabilities and needs, and a determination of goals and programming (IEP) to meet those goals. Recent research indicates that with proper intervention and coordinated training, these citizens can be much more independent and can possibly even function in a nonsheltered environment.

Components	Resources
Has an inservice workshop been held for teachers and aides in the management of toileting, diapering, hygiene? Who will plan the workshop; who will conduct the training?	See pp. 99-107 for Arizona Department of Health Services, Bureau of Child Development: "Toilet Training," and inservice packet, "Diapering and Perineal Care."
What equipment is needed for self-care on the part of the students? What equipment is needed for diapering, sanitary needs?	Toilet Training the Mentally Retarded by Richard Foxx and Nathan Azrin. Research Press, Box 3177 J, Champaign, Illinois 61820. $6.95 "Behavioral Technology," by Robert Schwitzgebel, in Handbook of Behavior Modification and Behavior Therapy, Harold Leitenberg, ed. Prentice-Hall, 301 Sylvan Ave., Englewood Cliffs, N.J. 07632. $34.95

6. Toilet Training (continued)

Components	Resources
Have other sources of funding been investigated to help pay for these expenses?	
Will supplies be disposable; will laundry service be needed?	
Who will be responsible for purchase of disposable supplies?	
What provisions are made for keeping records of children's toileting, sanitation?	
How will daily communication with the home be accomplished?	
What does the IEP say about the child's needs?	"Daily Living Skills" by Philippa H. Campbell, pp. 115-138, in Developing Effective IEPs for Severely Handicapped Children and Youth, Norris G. Haring, ed. Special Press, 724 So. Roosevelt, Columbus, Ohio 43209. $11.45 prepaid.

TOILET TRAINING

Procedures

1. Procedures will, of course, take individual differences into account, and they will vary accordingly.

2. A standard reference for toilet training is: Toilet Training the Mentally Retarded (Foxx and Azrin). It has been stated that these programs are too time consuming; however, as the child is progressively toilet trained (becomes more independent), less and less time is required of the teacher. Programs for acquisition (learning) are usually more time consuming that programs for maintenance (retention). It should be recognized that different children entering the public schools will be at different points in the acquisition and maintenance process.

3. Some curricula also contain toilet training programs.

Coordination between school and home environments

1. It is suggested that a single toilet training program, which contains school and home components, be constructed. The procedures for implementing the program should specify the exact actions of the teachers and home staff relative to the specific child. In this manner, the mechanism for coordination is the IEP conference, along with specific professional responsibilities (i.e., program writing). It is, therefore, important that representatives from the school and home program staff be present at the IEP conference.

2 Additional considerations are:

   a. An adequate conceptual and procedural understanding of the methods to be employed should be ensured; e.g., role-playing.
   b. Joint evaluations of procedural effectiveness should occur, along with joint decision-making regarding any change in the methods employed.
   c. Data should be collected daily in both home and school environments, and should be shared via communication books.

Diapering

See inservice training packet, "Diapering and Perineal Care."

Laundry service

1. The home has the responsibility for laundering clothing and

diapers.

2. The home should be encouraged to send sufficient clothing for needed changes during the day, along with an ample supply of diapers (if the program specifies that diapers are to be used).

3. Soiled or wet clothing and diapers should be returned in a plastic bag each afternoon/evening with the child.

Equipment

1. Foxx and Azrin's book describes some equipment used in toilet training programs, and it should be consulted for details.

2. Kurt Mahoney, Tempe, is developing a device for daytime toilet training (The Potty Pager), and it should be available in the near future.

3. Also, consult Robert Schwitzgebel's chapter, "Behavioral Technology," in the Handbook of Behavior Modification and Behavior Therapy.

Sanitation and odor

1. Preventive action is critical. Some programs specify frequent pants checks of children, thus, sanitation can be ensured and odor minimized by needed clothes changes which should accompany pants checks.

2. Soiled or wet clothing and diapers should be placed in plastic bags.

3. Spray disinfectant-deodorants are available, commercially.

Recordkeeping

Recordkeeping is an integral part of any program, and appropriate measurements should be devised by the interdisciplinary team for purposes of program evaluation (see Foxx and Azrin for sample data systems).

ARIZONA DEPARTMENT OF HEALTH SERVICES

BUREAU OF CHILD DEVELOPMENT

DIAPERING AND PERINEAL CARE

After reading this packet, you should be able to discuss the topics listed below. You will learn best if you carefully read the objectives and remember them as you read the text. Review them before you meet with the instructor. For this last review, remember that you have learned the necessary information if you can answer questions about the objectives listed below. If you have any questions, ask the instructor before you take the written examination.

The following is a list of questions you should be able to answer in your own words upon completion:

1. When should diapers be changed?
2. Where are soiled diapers placed?
3. Where do you place clothing that becomes soiled?
4. What position should the client be placed in to change his diaper?
5. How should diaper pins be placed? Why?
6. What should you do immediately before pinning the client's diaper?
7. Why shouldn't you pin over a bony area?
8. What type of client requires a forward diaper?
9. How is a forward diaper helpful to the client?
10. How should a forward diaper be pinned?
11. What type of client requires a backward diaper?
12. How is a backward diaper helpful to the client?
13. How should a backward diaper be pinned?
14. What type of client requires a security diaper?
15. How is a security diaper pinned?

16. How should the female client's genitalia be washed?

17. How and when should you mark a female client's menstrual flow?

18. How should you clean an uncircumcised male?

19. How should the B.M. chart be marked?

20. What observations should you report to nursing?

DIAPERING AND PERINEAL CARE

Objectives

Diapering and perineal care are important to the client for good health and hygiene. Diapering can be done in a variety of methods. It is important to know these methods of diapering so that you can diaper a client in the method that will be most therapeutic for him.

PART I: Diapering

Clients should be checked often for wet or soiled diapers, and changed whenever necessary. Check and change clients before meals, after meals, before dressing in the morning, before nap and bedtime, before and after programming sessions, as needed during the night, and any other times necessary.

Diapers are disposed of in the white laundry bags with other linen (i.e., washcloths, towels, etc.). If the client's personal clothing becomes soiled or wet, rinse them out in the toilet if necessary, and place them in the client's personal laundry bag (plastic).

When changing a client's diapers, it is extremely important to place his body in a relaxed position. This will help decrease the possibility of injury to the client. The client's legs should be bent at the hips and knees so that he cannot suddenly stiffen or arch his body. Maintain this position while you follow the diapering procedure:

1. Remove diaper pins and IMMEDIATELY close them. Place them out of the client's reach.

CAUTION: DO NOT put diaper pins in your mouth.

2. Clean the diaper area (buttocks and genitalia) with clear warm water. If the client has had a B.M., use "Peri-wash" with a warm washcloth. Be sure to wipe away from genital area.

3. Be sure to dry the client thoroughly to prevent the skin from drying and chapping.

4. Fold the diaper in the prescribed method being certain that the soft "textured" side is against the client.

5. Carefully, but snuggly, pin the diaper on the client. The pins should always be perpendicular to the client's spine (straight

across with the head pointing to the outside of the client's body). This will decrease the possibility of the pin opening accidentally as well as the possibility of injury to the client.

CAUTION: BEFORE pinning the diaper, place your fingers between the diaper and the client to prevent sticking the client with a pin. This rule is to be followed AT ALL TIMES.

HINT: If the pin does not slide easily through the diaper material, place the pin in a bar of soap. DO NOT run the pin through your hair, as this is very unsanitary.

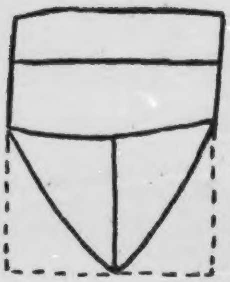
CAUTION: NEVER pin over a bony area. This can cause pressure points.

6. Check to make sure all pins are accounted for. If one is misplaced, do NOT leave the client until it is found.

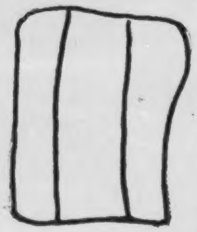
Each client has a prescribed diapering technique. At CDC, these techniques are listed in each team area. If you are unsure of the techniques with individual clients, always check to be sure you are using the correct one. These techniques were prescribed according to individual client needs, and must be used consistently to be the most therapeutic.

FORWARD DIAPER

Loose or floppy clients require a "forward diaper" to assist in bringing their thighs closer together.



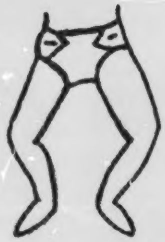
1. Fold the diaper to the appropriate size to fit the client with one end slightly narrower than the other. For smaller clients, a large diaper may be folded as shown on the left. An extra diaper may be folded into thirds and used for extra absorption, as shown on the right.



2. Place the folded diaper under the client, the wider end at his back.

3. Pull the diaper up between the client's legs snuggly.

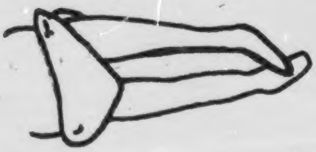
4. Pin the back corners of the diaper over the front corners (as shown on right).



BACKWARD DIAPER

Stiff clients require a "backward diaper" to assist in pulling their legs apart.

1. Fold the diaper to the appropriate size to fit the client, with one end slightly narrower than the other.
2. Place the folded diaper under the client, the narrower end at his back.
3. Grasp the client's knees above the knee joint and slowly bend his hips and knees up as far as they will go. At the same time, slowly and gently spread his thighs apart. Maintain this position. If necessary, lean against the client's legs with your abdomen--very gently.

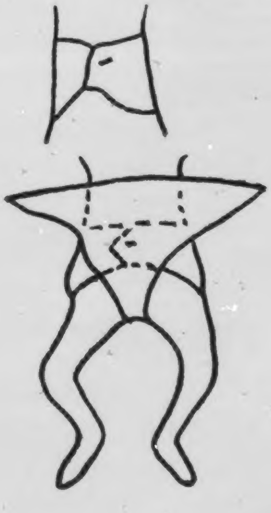


4. Pull the diaper up between the client's legs snuggly, pulling his legs apart.
5. Pin the front corners of the diaper over the back corners (as shown on the left).

SECURITY DIAPER

Clients who play with their feces or have trouble keeping a diaper from slipping off require a security diaper.

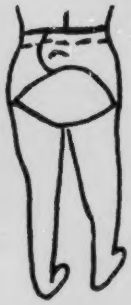
1. Place an unfolded diaper under the client.
2. Fold a second diaper into thirds and place this inside the first diaper for better absorption.
3. Pin the back corners of the diaper in front at the client's waist, as shown on the right.
4. Fold the outside of the front of the diaper inward under the client's legs to form a triangle.
5. Pull the diaper with the pad up between the client's legs snuggly.



6. Open folds and grasp one front corner in each hand. Gently turn the client over on his stomach.

7. Pull the diaper snuggly around the client's legs, as shown on the right.

8. Gather the diaper around the client's waist and pin in the back as shown. Do NOT pin all the way through the pad.



CAUTION: Do NOT pin directly over the spine. Gather the diaper and pin slightly to the left or the right of the spine.

PART II: Perineal Care

Perineal care must be given at least once a day and after each bowel movement.

Female

1. Using a warm, soapy washcloth, clean genitalia gently but thoroughly.

2. Separate the vulva and carefully wash from front to back with a cotton ball. Do this only one time and throw the cotton ball away immediately. Repeat if necessary.

3. Rinse well.

4. Dry thoroughly to prevent chapping.

Female (during menstrual cycle)

1. Place the sanitary napkin with the blue strip away from the skin.

2. Soiled sanitary napkins should be wrapped in paper and discarded in the waste receptacle. Do NOT flush down toilet.

3. Mark each day the client is having a menstrual flow with a red star on the BM sheet.

Male (circumcised)

1. Using a warm, soapy washcloth, clean genitalia gently but thoroughly.
2. Rinse well.
3. Dry thoroughly to prevent chapping.

Male (uncircumcised)

1. Gently pull back the foreskin and wash with a warm, soapy washcloth.
2. Rinse well.
3. Dry thoroughly to prevent chapping.
4. Apply a thin coat of vaseline to the head of the penis and pull the foreskin back into place.

General Rules for Perineal Care

1. Use a soapy washcloth and/or "Peri-wash" only during bath time and after a B.M. Clear water will be adequate for other times and will help prevent dry skin.
2. Mark each day of a female client's menstrual period with a red star on the B.M. chart.
3. Mark each B.M. on the chart with a description of size and type for each client. (See B.M. code in team areas.)
4. Report all unusual observations to the team leader and team nurse immediately (i.e. rash, discharge, etc.)

Prepared by: Tammy L. Cales, BCD In-Service Coordinator
July, 1978

7. TRANSPORTATION

Planning transportation for moderately or severely handicapped students requires an individualized approach based on the unique needs of each student. Close communication must be maintained between the home or the group home and the school to assure that students will be ready for the bus and that someone will be at home to receive the students at the end of the day. Specialized equipment, trained drivers and trained aides to accompany the students will be needed. Planning must take into consideration the physical endurance limitations of some of these students, and assure that the students do not expend more time than is absolutely necessary on traveling to and from school. The transportation needs should be listed under related services on the child's individualized education program.

Components	Resources
Equipment	
How will students be transported?	HB 2426/ARS, 15-1015.A.4, p.181.
What types of vehicles are available?	
Will new vehicles be needed?	
Method of obtaining?	
What special equipment will be needed, e.g., wheelchair lifts, car seats, seat belts, harnesses, prone position carriers, etc.?	Equipment distributors: Auto Safety House Phoenix, Arizona
Can some of the students ride regular buses?	
Can cooperative arrangements be made with other districts to share costs/ use of special equipment?	
Are loading, unloading areas adequate, safe, comfortable for students and staff?	
Personnel	
What ratio is necessary for children:staff on the bus?	

7. Transportation (continued)

Components	Resources
Personnel (continued)	
What staff training is necessary?	See p. 110 for inservice training outline for bus drivers and bus aides.
Who will function as aides on bus?	
What training is necessary for dealing with medical or discipline problems on the bus?	
Does training include proper management of behavior problems? How does management on the bus relate to the child's IEP?	
Who will develop training programs?	
Who will provide/ receive training?	
Who is responsible on the bus?	
Who is responsible for getting students on/off bus at school, at home?	
Who is responsible at the bus stop?	
How shall competencies of personnel be evaluated? How often?	
Who will develop and coordinate routes with need/time/aides?	
Do you have a job description for bus personnel?	
Have funding sources for training been investigated?	

TUCSON UNIFIED SCHOOL DISTRICT
IN-SERVICE TRAINING PROGRAM*

Bus Drivers and Aides

Time Period: One 6-hour day per month for all new personnel

Equipment needed: 84 passenger bus, mini-bus, wheelchair, carrying seat, etc.

OUTLINE

1. Role as Driver and Aide

   Rules, team member, relationship with parents, teaching social skills, handling, attitude, patience and tolerance, etc.

2. Identification of all types of handicaps

3. Limitations of some children

   Mobility, communications, medical problems, etc.

4. Putting limits on children

   Dependency, inconsistency, assuming, etc.

5. Orientation to specialized equipment

   Shoulder harnesses, straps, belts, headrests, wheelchairs, lifts, etc.

6. Training on emergency procedures

   Seizures, choking, coma, etc.

7. Films

   "How To Lift"
   "Heimlich Maneuver"
   "Epilepsy"
   Demonstration on proper lifting and handling of children and equipment

8. Behavior Modification

   Demonstration on the bus for typical behavior problems

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*This outline comes from an extensive aide-training curriculum from the Tucson Unified School District, P.O. Box 4040, Tucson, Arizona 85717

8. MEDICAL

The physical involvement that is part of the profile of the severely and profoundly handicapped child is a basic consideration in planning the child's educational program. When the physical and medical assessment information is received by the school, the educational team must plan an IEP that includes ways of dealing with the child's physical impairments. With procedures and policies clearly outlined and staff properly trained, medical care can be a routine part of the everyday operation of the classroom and the school.

Components	Resources
Have pertinent medical records been transferred to school?	
Immunizations?	
Medications?	
Allergies?	
Possible emergency situations and treatment, especially as associated with syndromes and other medical conditions?	See pp. 140-144 also for emergency resources.
Others?	
Have results of medical and physical assessments been utilized in writing the student's IEP (e.g., positioning needs, rest requirements, strength and stamina, control of seizures, etc.)?	"Development of Individual Education Programs," by Eugene Edgar, pp. 15-38 in Developing Effective Individualized Education Programs for Severely Handicapped Children and Youth, Norris G. Haring, ed. Special Press, 724 S. Roosevelt Ave., Columbus, Ohio, 43209 $11.45 prepaid.

8. Medical (continued)

Components	Resources
What special medical equipment needs are indicated?	See student's IEP, IPP.
Oxygen?	
Colostomy?	
Catheterization?	
Other?	
What are sources for this equipment?	SSI/Disabled Children Program (Appendix D, p. 169).
What procedures have been set up to deal with medications?	See sample forms, pp. 114-116.
Written records of protocol?	The Division of Special Education recommends that any arrangements made regarding staff assignments to perform medically related functions be done with the written approval of the child's parent and physician.
Directions for dosage, monitoring?	
Storage, equipment for storage?	
State regulations?	
Forms?	
What training is available for staff in meeting medical needs, especially with more complicated procedures?	Consult DD/MR case managers, family physician or school consulting physician if available.
CPR (cardiac pulmonary resuscitation)?	
Heimlich Maneuver?	
Colostomy?	
Catheterization?	
Other?	

8. Medical (continued)

Components	Resources
Is there a crisis model for dealing with emergencies?	
Procedures?	
Persons to inform: medical staff, parents, group home, hospital, etc.?	
Forms?	
Emergency numbers?	

ADMINISTERING MEDICINES TO STUDENTS

ROOSEVELT SCHOOL DISTRICT NO. 66
6000 South 7th Street
Phoenix, Arizona 85040

Date________________

________________School

REQUEST FOR GIVING MEDICATION AT SCHOOL

Name______________________________ Grade__________

Teacher___________________________ School__________

Medication____

Time to be given__________a.m. Time to be given______p.m.

Date from ____________________ to ____________________

I hereby authorize____________________, ______________
(Name) (Position)

to be my agent to give the above named medication to my child,

__________________________,as ordered by Doctor__________
(Child's Name)

______________________________.

☐ This is a prescription which will be furnished by the parent or guardian and is labeled in an original prescription bottle with student's name, name of medication, amount to be given, time of the day to be given, and duration of treatment.

☐ This is a patent or proprietary medication furnished by the parent or guardian and the medication is provided in the original container.

______________________________ ______________
Parent or Guardian's Signature Date

______________________________ ______________
Address Phone number

______________________________ ______________
Physician's Signature Phone number Date

____
Principal
Adopted 8/3/76
Revised:
RSD

SAMPLE FORM
FOR CUMULATIVE FOLDER*

Name: ____________________

birthdate: ____________________

social security number: ____________________

Parent or Guardian: ____________________

telephone number: ____________________

Doctor: ____________________

telephone number: ____________________

Hospital: ____________________

telephone number:

Information for Hospital Admission: ____________________

insurance type and number: ____________________

____

____

Medicine: ____________________

amount taken: ____________________

time of day to be taken: ____________________

Allergies: ____________________

____

Special habits: ____________________

____

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* From Operating Mannual for Residential Services Personnel, 1974 V.F. Holland and R.F. Rubeck, eds. Nisonger Center for Mental Retardation and Developmental Disabilities.

Sample, continued

Likes and dislikes:____

____

Dietary restrictions:____

____

Special Comments:____

____

____

____

____

Special Comments:____

Agency contacts:____

Protective Services:______________________________________

telephone:____

Case Manager:____

telephone:____

Welfare Worker:____

telephone:____

Other:____

telephone:____

Religious preference:____

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9. STRATEGIES FOR DEALING WITH PROBLEM BEHAVIORS

Behavior modification and behavior management techniques have been useful in helping change students' maladaptive behaviors. Personnel (teachers, aides and administrators) must have a firm grasp of the hierarchy of techniques and know that punishment alone may not be as useful in changing behavior as is positive reinforcement of desired behavior. Disciplinary action, when required, must be based on firm, logical reasons, and not on spontaneous reactions. The issues that surround student discipline, both for and against, have long occupied educators. According to Reed Martin, in Baker v. Owen, 395 F Supp. 294 (1975), the Supreme Court ". . . indicates that corporal punishment must follow written rules, the offenses must be bad enough to merit this type of punishment, other less severe approaches must be tried first, and the age and physical condition of the child must be considered." Martin continues that in a later ruling, Ingraham v. Wright, 45 U.S. Law Week 4364 (April 19, 1977), the Supreme Court ". . . indicated a special concern for the mentally handicapped who might suffer unreasonable punishment and not complain about it. Ingraham also stated that the proper redress against unreasonable corporal punishment was not in federal court on a constitutional theory but to pursue criminal charges and seek money damages in a civil action" (p. 38). (Martin. Workshop Materials: Educational Rights of Handicapped Children. Research Press Company, 2612 North Mattis Avenue, Champaign, Illinois, 61820. $19.95.)

Components	Resources
Does the IEP include goals for appropriate behavior and strategies to achieve same? Is there a plan and method for communication between school and home on the coordination of behavioral objectives of the IEP? Are guidelines available in written form for carrying out the behavioral treatment?	See pp. 119-135 for Arizona guidelines for institutions and public schools, litigation analysis, etc.

9. Strategies for Dealing with Problem Behaviors

Components	Resources
Is there a form for reporting and documenting discipline and behavior?	
Does the staff know the alternatives to the use of corporal punishment?	
Is the staff aware that corporal punishment is prohibited by DD/MR standards?	
What conditions in the physical environment are necessary for implementing a behavioral objectives program? (Both for a positive intervention strategy and punishment.)	
Do all personnel understand the responsibility of using the mildest appropriate form of intervention in dealing with behavior problems?	
Have all personnel been involved with workshops on how to deal appropriately with discipline?	
Have all personnel been informed of the liabilities of inappropriate responses to behavior problems?	
Are review procedures in place for disciplinary actions?	

STRATEGIES FOR DEALING WITH PROBLEM BEHAVIORS

Supplementary Information Outline

1. State Legislation

    a. Institutions
    b. Public schools

2. Abstracts of guidelines, regulations, and suggestions
    a. Institutions

        1. Behavioral Intervention Hierarchy, Bureau of Mental Retardation, District #1
        2. Standards for Services for Developmentally Disabled Individuals, by Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons

    b. Public Schools

        Discipline Resource Guide: Suggestions from the Discipline Task Force, Arizona Department of Education

3. Litigation

    Stuart v. Nappi

4. Liability

5. Documentation

6. Coordination between school and home environments

7. Resource material

    a. Legal
    b. Programmatic

8. Issues

A.R.S. Section 36-561. Prohibiting certain treatment or drugs; use of aversive stimuli

I. No psychosurgery, insulin shock or electroshock treatment or experimental drugs shall be administered by the Bureau to any client.

II. The Bureau shall adopt rules and regulations specifying the aversive stimuli used for any mental retardation program or service provided directly by, licensed and supervised by, or supported by the Bureau. Copies of such rules and regulations shall be made available to all parents, guardians, applicants and clients participating in placement evaluations. The Bureau shall provide at least sixty days notice to all responsible persons prior to implementing any modifications to such rules and regulations. No aversive stimuli shall be used or permitted by the Bureau in any such program or service except in accordance with the adopted rules and regulations.

A.R.S. Section 36-569. Prohibitions; violations; classification

I. Improper, abusive treatment or neglect of a mentally retarded person is prohibited. For the purposes of this section:

A. Abusive treatment means:
  1. Physical abuse by inflicting pain or injury to a client. This includes hitting, kicking, pinching, slapping, pulling hair or any sexual abuses. Minimal corporal punishment for disciplinary reasons shall not be construed to be abusive treatment.
  2. Emotional abuse which includes ridiculing or demeaning a client, making derogatory remarks to a client or cursing directed toward a client.
  3. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as a part of such person's individual program plan or which is not contained in the rules and regulations adopted pursuant to Subsection B of Section 36-561. This includes isolation or restraint of a client.

B. Neglect means:
  1. Willful lack of attention to physical needs of clients such as toileting, bathing, meals and safety.
  2. Failure to report client health problems or changes in health condition to immediate supervisor or nurse.
  3. Sleeping on duty or abandoning work station.
  4. Deliberate failure to carry out a prescribed treatment plan for a client.

State Law: Institutions

II. A person who intentionally violates any provision of this section is guilty of a Class 2 misdeameanor.

III. Any client or the parent or guardian of a minor client or the guardian of an adult client who believes that his rights, as established by this Chapter or by The Constitution of the United States or by The Constitution of Arizona, have been violated shall have a right to petition the Superior Court of Arizona for redress.

STATE LAW: Public Schools

References to discipline appear in several sections of the Statutes. The ones cited below address the responsibilities and duties of teachers, students, and the boards of trustees of the schools. Expulsion must now be viewed in the context of the recent (February, 1978) Stuart v. Nappi case.

A.R.S. Section 15-201. Duties of teachers

Every teacher shall:

4. Hold pupils to strict account for disorderly conduct.

A.R.S. Section 14-305. Responsibilities of pupils; certain causes for expulsion

Pupils shall comply with the regulations, pursue the required course of study, and submit to the authority of the teachers and the governing board.

Continued open defiance of authority or habitual profanity and vulgarity, constitute good causes for expulsion.

A.R.S. Section 15-442. General powers and duties

The board of trustees shall:

14. Hold pupils to strict account for disorderly conduct on school property and provide for adequate supervision over pupils in all instructional and noninstructional activities.
15. Hold pupils to strict account for disorderly conduct on the way to and from school.

ABSTRACT

Behavioral Intervention Hierarchy, by Richard C. Keefe and
Marjory Vin Williams, Bureau of Mental Retardation-
District #1. (DRAFT document)

I. The Behavioral Intervention Hierarchy is, in essence, a draft of a set of regulations for the usage of intervention procedures in the Bureau of Mental Retardation, District #1. It is designed to regulate the behavior of those who actually apply the intervention techniques (teachers, trainers and other staff).

II. Approach

The approach is positive in nature; the aim is toward teaching age-appropriate and sex-appropriate behaviors. Whenever an inappropriate behavior is to be reduced, the program must also specify the appropriate behavior which is to replace the inappropriate behavior. A client is, therefore, taught what to do, as well as what not to do.

III. Methods

A. In the Behavioral Intervention Hierarchy, an attempt is made to devise a continuum of intervention procedures, and it is scaled according to levels which are to represent progressively stronger forms of intervention (from positive, to mildly aversive, to moderately aversive, to highly aversive).

B. Positive techniques are to be utilized first; thus, inappropriate behavior is indirectly eliminated by reinforcing an appropriate behavior or set of behaviors.

C. If positive techniques are not effective, then more aversive procedures can be used for reducing inappropriate behavior. Mildly aversive techniques are to be used before moderately or highly aversive ones.
   1. Whenever aversive techniques are to be applied for reducing inappropriate behavior, positive techniques must be used concurrently to teach appropriate behavior.[1]

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[1] The justification for this practice may extend well beyond, but is still related to, philosophies of teaching and human rights issues. Current and past research suggests that reinforcing an appropriate, alternative response (used in combination with punishment of an inappropriate response) may make punishment of the inappropriate response more effective. In addition, lower intensities of punishing stimuli may be just as effective as higher intensities when this combination procedure is used. Though this generalization from research must be construed as provisional, it has strong implications for teaching and human rights.

Behavioral Intervention Hierarchy (continued)

2. Special provisions are made to allow useage of moderately or highly aversive techniques without first using mildly aversive ones. Ample justification must be provided, however.

IV. Review procedures

A. Review procedures are dependent on the level of intervention.

B. A behavior management committee and the human rights committee review techniques at the most aversive levels. Usage also requires client and/or parental or guardian consent at more aversive levels.

V. Supervision

Written specification of how supervisors will monitor programs is required.

ABSTRACT

Standards for Services for Developmentally Disabled Individuals: Behavior Management, Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled persons

I. These standards refer to the modification of maladaptive behaviors and efforts to replace them with more adpative behaviors.

II. Approach

The approach is positive in nature; it emphasizes development of adaptive behaviors, rather than elimination of maladaptive behaviors.

III. Methods

A. The agency must have a written policy which defines the use of behavior modification programs, staff members who may authorize usage, and a mechanism for monitoring and controlling usage.

B. In accordance with the positive approach, reliance on punishment (direct behavior reduction techniques) as the primary means of behavior control is unacceptable. Methods which directly increase adaptive behaviors are to be used concurrently.

Standards for Services for Developmentally Disabled Individuals. . . (continued)

C. Methods used must represent least restrictive alternatives, and programs should be designed which eventually lead to even less restrictive methods of behavior management.
   An individual's record must document the use of less restrictive methods and their ineffectiveness before more restrictive methods are used.

D. Corporal punishment is to be prohibited by written policy and is not to be employed.

IV. Review Procedures

A. Each program which involves the use of aversive conditioning and time-out from positive reinforcement must be reviewed and approved prior to implementation.
   Programs must be reviewed by the agency's behavior management committee, the agency's human rights committee, and conducted with the consent of the affected individual and/or the individual's family.

V. Supervision

A. There must be a written policy which specifies a mechanism for monitoring usage of behavior modification programs.
   Removal from a situation for time-out purposes must occur under direct observation of persons conducting the program.

ABSTRACT

Discipline Resource Guide:
Suggestions from the Discipline Task Force
Arizona Department of Education

I. The Discipline Resource Guide points out that the essential problem is one of providing appropriate discipline within the context of due process. The Discipline Resource Guide provides an overview of five areas: alternative approaches to discipline; corporal punishment; due process; searches, seizures and warrants; and recordkeeping.

II. Approach

A positive discipline program is suggested. Application of disciplinary procedures should be directed toward improving individual and group behavior. An attempt should also be made to create an atomosphere conducive to learning, order, safety, and control, and to maintain that atmosphere. The means of accomplishing this is by training, "individual responsibility," and "mutual respect." It is assumed that the best discipline is preventive in nature and should be applied mainly from "within the individual."

III. Methods

A. Discipline is to include prevention of disruptive behavior by methods such as: effective classroom management, teacher in-service, individualization of programs for students, emphasis on approaches that promote development of self-discipline and good decision-making. In addition, gradations of consequences are to be applied as problem behavior occurs and increases.

As consequences increase in severity, so does the importance of adherence to due process and recordkeeping procedures.

B. Adults (educators and parents) are responsible for positive reinforcement of successful student behavior and modeling of appropriate behavior.

C. Other methods include clear exposition of rules and expectations.

D. Alternatives to the use of physical punishment are specified in a separate section and are grouped into short-range, intermediate-range, and long-range solutions.

The alternatives require fairly sophisticated methods, many of which involve extensive communication and negotiation between students and teachers (e.g., student-teacher agreement on immediate alternatives, discipline policies which are developed jointly by students and school staff, and full involvement of students in the decision-making process).

E. Corporal punishment is permitted, but authorization for its use remains with the local school board.

Corporal punishment should be used as a last resort, prior to suspension or expulsion. It may not be administered for academic deficiency or conduct unrelated to school.

IV. Review Procedures (for corporal punishment)

Technically, there are no external or third-party review procedures as such. However, the "school official" administering corporal punishment engages in what can be called

Discipline Resource Guide: Suggestions....(continued)

a self-review. "Prior to administering corporal punishment, a school official should assure him/herself: a) that the offense warrants corporal punishment, b) that no warning statements, for example medical or parental, in the child's record would forbid corporal punishment, c) that a proper witness is present, and d) that he/she is not acting in anger or out of spite."

V. Supervision (for corporal punishment)

"Supervision" takes the form of having an adult employee of the school present to witness and monitor any administration of corporal punishment. It is suggested that this witness be an administrator or his/her designee in order to insure compliance with the guidelines.

LITIGATION

Stuart v. Nappi, Civ. No. B-77-381 (D. Conn., January 4, 1978)[2]

I. Decision: A federal court held that handicapped children may not be expelled.

> This was the first federal case to be decided solely on the basis of the Education for All Handicapped Children Act of 1975 (PL 94-142).

II. The federal court cited three reasons why a handicapped child cannot be expelled under current federal law:

  A. Least restrictive alternative: expulsion would violate the right to services in the least restrictive alternative, as established under PL 94-142.

  B. Due process before placement change: the expulsion would bring about a change in placement without following due process procedures. Homebound instruction following expulsion would be a change in placement, according to the court.

  C. No change in placement can occur while a hearing is pending, unless the state or local educational agency and the parents or guardian otherwise agree.
  In this particular case, the parents did not agree.

III. Can the schools discipline students?

> In the court's words: "It is important that the parameters of this decision are clear. The Court is cognizant of the need for school officials to be vested with ample authority and discretion. It is, therefore, with great reluctance that this Court has intervened in the disciplinary process of Danbury High School. However, this intervention is of a limited nature. Handicapped children are neither immune from a school's disciplinary process nor are they entitled to participate in programs when their behavior impairs the education of other children in the program. First, school

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[2] The above information was obtained from the publication, Law and Behavior: Quarterly Analysis of Legal Developments Affecting Professionals in Human Services, by Reed Martin, Champaign, Illinois: Research Press, Vol 3, No. 2, Spring, 1978.

Litigation (continued)

> authorities can take swift disciplinary measures, such as suspension, against disruptive handicapped children. Secondly, a (professional team) can request a change in the placement of handicapped children who have demonstrated that their present placement is inappropriate by disrupting the education of other children. The Handicapped Act thereby affords schools with both short-term and long-term methods of dealing with handicapped children who are behavioral problems."

IV. This case also places responsibility on the schools for developing an appropriate environment in which to deliver services. The school cannot "flush the child away" through disciplinary measures.

LIABILITY

I. General considerations

A. In practice, there must be "substantial injury" before a liability case is accepted by an attorney.

Liabilities will generally include: exclusion from school (see Stuart v. Nappi) and inappropriate placement of a child.

B. The basic liabilities for disciplining a "normal" child would apply in the case of a developmentally disabled child; however, it is not yet clear what additional liabilities would apply, in addition to those listed above. This is because no legal precedents have been established.

Currently, there is no constitutional liability for corporal punishment (Ingraham v. Wright); however, A.R.S. Section 36-569 states that only minimal corporal punishment of retarded persons shall not be construed as abusive. This term, "minimal corporal punishment," is ambiguous, and the law applies only to institutions.

C. As a general rule, as the severity of the method of discipline increases, so would the potential liabilities, particularly if a less severe method could have been used.

II. Professional liability insurance is recommended.

DOCUMENTATION

I. The reasons for documenting vary. Accordingly, those reasons will dictate the types of items to be included when recording instances of disciplinary action.

II. Statistical Purposes

The Discipline Resource Guide states that: "the basic goal of discipline recordkeeping formats should be to have available at least once a year on a summary basis the number of students disciplined by corporal punishment, suspension, expulsion, and transfer to alternative classes or programs."

It was recommeded that monthly summaries of discipline cases administered in districts be prepared and submitted to local school boards. A checklist of suggested items is included in the Discipline Resource Guide.

III. Legalistic Purposes

The Discipline Resource Guide says that a log which lists the procedural history of each discipline case should be maintained whenever a child is disciplined until the student reaches the age of 20.

The log of each district should be designed to give the district protection in the event of court action. The Discipline Resource Guide contains a checklist of suggested items.

IV. Evaluative Purposes

A. If "disciplinary actions," or more accurately, situations in which teachers apply given techniques to the maladaptive behavior of a developmentally disabled children, are viewed as education, then "documentation" becomes a matter of evaluating treatment/teaching technique effectiveness. As such, documentation is synonymous with monitoring, evaluation, or data collection.

This is the most typically adopted in the institutional setting.

B. When actions of developmentally disabled persons which warrant the application of disciplinary procedures are viewed in an educational context, certain regulations apply.

The Rules and Regulations for PL 94-142, Section 121a.346 Part (e) states that the IEP for each child must include: "Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional objectives are being achieved."

C. Data systems for purposes of evaluating the effectiveness of treatment/teaching methods should provide:

1. Quantitative information

   Frequency, duration, and/or intensity indices allow an adequate determination of whether the problem behavior is decreasing, remaining at the same level, or even increasing. Treatment/teaching methods are then revised accordingly.

2. Qualitative information

   a. Ideally, a data system should also be a teaching device for teachers/trainers. It can prompt an awareness of the way in which their behavior influences the behavior of their students/clients. In addition, it can provide information regarding the events which may contribute to, or cause, the problem behavior. This information contributes to the development of more effective methods of intervention.

   b. Qualitative items might include:

      i) Description of the intiating event (the event which might have caused or is at least associated with the start of the problem-behavior episode).

      ii) What form did the problem behavior assume (exactly what did the student do)?

      iii) What was the student doing when the problem behavior occurred?

      iv) What was the setting: room, other persons in immediate vicinity - or even, what persons were conspicuoulsy absent, etc.?

      v) Time of occurrence.

      vi) What did the teacher do when the student displayed the target behavior?

      vii) How did the student react?

      viii) What activity did the student engage in immediately after the problem behavior terminated?

V. Legalistic and evaluative features could be incorporated into a single format.

COORDINATION BETWEEN SCHOOL AND HOME ENVIRONMENT

Coordination is itself a complex task. In addition, maladaptive behavior is often situational; it may occur at school, but not at home, and vice versa. Accordingly, different methods may be used in different environments, but a single program, which contains school and home components, should be constructed. At a minimum, coordination should include:

A. An adequate conceptual and procedural understanding of the methods to be employed.

Role-playing of the methods by all parties is encouraged to ensure consistent and standardized application.

B. Joint evaluations of treatment/teaching technique effectiveness should occur, along with joint decision-making regarding any change in the methods employed. This is to be encouraged, even if differential techniques are used in the school and home environments. Procedural variations should, therefore, not be attempted by one party, unless they are first communicated to the other party. This will encourage ongoing communication between the school and home.

C. Data should be collected daily in both home and school environments, and should be shared via communication books.

RESOURCE MATERIAL

I. Legal

A. Law and Behavior: Quarterly Analysis of Legal Developments Affecting Professionals in Human Service.

B. Mentally Retarded Citizen and the Law, Free Press, by Michael Kindred, 1976. 866 Third Avenue, New York, N.Y., 10022. $18.75.

C. Mentally Disabled Law Reporter, American Bar Association

D. The Rights of the Mentally Retarded, American Civil Liberties Union

II. Programmatic

A. The technical literature on techniques to reduce maladaptive behavior is voluminous, and there is no single source. The following sources can provide a reasonable background.

1. Journal of Applied Behavior Analysis
2. Behavior Research and Therapy
3. Behavior Therapy
4. Behavior Modification
5. Behavior Modification and Experimental Psychiatry
6. Journal of Consulting and Clinical Psychology
7. Behavior Modification in Applied Settings, by Alan E. Kazdin, 1975. Dorsey Press, 1918 Ridge Road, Homewood, Illinois, 60430. $8.50.
8. Principles of Behavior Modification, by Albert Bandura, 1969. Holt, Rinehart and Winston, 383 Madison Avenue, New York, N.Y., 10017. $15.95.

ISSUES

I. It is critical to distinguish between "breaking the rules" and maladaptive behaviors which are associated with a child's developmental disability. In the former case, the school's disciplinary policies clearly apply. In the latter case, are we talking about discipline in the traditional sense, or can "treating" maladaptive behaviors associated with developmental disabilities be construed as education? If this argument is valid, then the appropriate mechanism for "treatment" of maladaptive behavior is the IEP conference, and the methods of treatment should be designed at that conference. This would also ensure that objectives would be written regarding maladaptive behaviors (appropriate behaviors would be targeted). As such, does this imply that the school's disciplinary policies may not apply to some of the behaviors of a developmentally disabled child?

II. Though corporal punishment may be administered in the public schools (Ingraham v. Wright), there is a potential conflict with state laws which applies to institutions and also accrediatation standards. State law says that only mild corporal punishment may be used (whatever that means), while accreditation standards clearly state that corporal punishment is forbidden. To what extent, if any, can corporal punishment be administered to a developmentally disabled child?

III. If a disagreement occurs at an IEP conference over the choice of a treatment technique for maladaptive behavior, what is the mechanism for resolution? Would the normal channels apply (hearing officer and the courts)? This is complicated, because two separate state agencies are involved. It can be argued that a hearing officer is employed by the Department of Education. If so, does this pose a conflict of interest?

10. PARENTAL RESPONSIBILITIES

Both Arizona State laws and PL 94-142 require prior notice to parents, informed parental consent, and active parent participation at specific points in the delivery of educational services to a handicapped student. Administrators must identify who is authorized to serve as the parent for students who have been institutionalized; once a determination has been made, the authorized person will participate in the educational decision-making process at the same points that a natural parent would.

Considerations	Resources
Who is the "parent" in the legal sense for the child?	See p. 137.
Does the school have proper permission forms?	
Has the school developed a means of working cooperatively with the BMR in formulating the IPP and IEP?	HB 2426/ARS 15-1015 D and 36-554.01 B, pp. 182 and 192.
Has the school chosen a representative(s) from the school to help develop the plans?	
Is it possible to develop the plans at one meeting where all concerned parties are involved?	
Is the school in communication with the parent and is the school complying with the regulations concerning parental information and consent?	
Has the school informed parents of their rights concerning confidentiality of their student's educational records, impartial due process hearings and procedural safeguards?	
Has the school developed a means of regular communication with the parent or group home parents? With both if both are involved?	

PARENTAL RESPONSIBILITIES

For some persons living in Bureau of Mental Retardation*Community Residential Alternatives, the Bureau will act as the parent in some cases where authorized by the parent (see attached form). In such instances the school should involve the authorized representative from the Bureau as they would any parent. If the BMR is not authorized to act as parent for a student attending public school, the school should then involve the parent as they would other parents.

In HB 2426 (15-1015 D and 36-554.01 B) it is clearly stated that the public schools and the BMR shall coordinate the development of the Individual Educational Plan (IEP) and the Individual Program Plan (IPP). This requires both agencies to involve representatives as part of the team. The intent of this coordinated effort in developing IEPs/IPPs is to ensure that programs for one child are designed and implemented to maximize the development of that child. The representatives from the Bureau would be the case manager and a representative of the group home; the representative from the school would be designated. Other personnel from either system might also be called upon. It is suggested that, if at all possible, it would be beneficial to have the IEP and IPP meetings held as one meeting, however, there are some time requirements and strategies that must be addressed to adequately plan such meetings.

If disagreement is found at either an IEP or IPP meeting, the service developing either the IEP or IPP should proceed with their appropriate appeals/due process procedures to handle such matters.

To facilitate communication on the progress of the student after the objectives have been agreed upon, it is recommended that a communications notebook be developed for each child to send back-and-forth from the school to-and-from the residential program; the notebook could be used to document progress/problems on a day-to-day basis.

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*Now Division of Developmental Disabilities/Mental Retardation

DRAFT LETTER

from the ARIZONA DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES/MENTAL RETARDATION
1400 WEST WASHINGTON, PHOENIX, ARIZONA 85006

CONSENT FOR SCHOOL ACTIVITY
SPECIAL EDUCATION SERVICES

I hereby authorize and delegate to the DES-DD/MR (____________________)
Unit
authority to sign consents on my behalf for the following public school activities for ______________________________.
Name of Child

*____ Consent for Evaluation

____ Consent for Placement in Special Education Program

____ DD/MR shall represent me at the IEP meeting

____ Review of and continuation of Placement

____ Field Trips off Grounds

____ Release of Information

____ Other (specify) _______________

____ Permission to Terminate Placement

Date ______________________ ____________________________________
(Responsible Person)

*Instructions

Parents are to check off the items they are willing to delegate to DD/MR. If an item is not checked, the parents need to be contacted by the school for those items.

11. EMERGENCY RESOURCES

Emergency resources should be available for all students. With satisfactory emergency plans in place and personnel (including paramedics) thoroughly informed and trained, and with periodic review and drill, all concerned persons should be able to feel that emergencies can be taken care of expeditiously and professionally with the highest degree of comfort and safety for all children involved.

Components	Resources
Do you have written procedures for action during emergencies?	See p. 140, "Paramedics."
Are these procedures posted in conspicuous places?	See p. 141 for sample form, "Emergency Telephone Numbers." See pp. 78-79 for "Fire and Evacuation Procedures."
In case of family crises, are there agencies to call for respite care, clothing, sitter, home care, nursing?	DD/MR (see Residential Services on matrix, pp. 12-14).
Are frequent, periodic reviews held to keep emergency services current?	
Is the staff trained in techniques to use during seizures, choking, etc.?	
Is a school nurse available full time?	
Do the child's school records contain releases for emergency services?	See pp. 142-144, from Operating Manual for Residential Services Personnel, 1974. V. F. Holland and R. F. Rubeck. eds. Nisonger Center for Mental Retardation and Developmental Disabilities, 1580 Cannon Dr., Columbus, Ohio 43210

PARAMEDICS

When a child is in acute distress (experiencing symptoms which may be life threatening), this procedure is to be followed:

1. Call for additional personnel.
2. Make child safe from self-injury.
3. Deploy one person to call paramedics.
4. After paramedics are called, telephone parents.

Prior to an emergency condition, invite the local paramedics unit to tour the facility housing high-risk children.

Provide emergency parking.

Clearly mark entrances to area where sick/injured will be found. Places near the nurses's office, etc., are suggested.

If the child is not in the usual health services area, a person should be sent outside of the building to direct the paramedics to the child.

EMERGENCY TELEPHONE NUMBERS*

Fire Station: ______________________

____

Police Department: ______________________

____

Ambulance: ______________________

Life Squad: ______________________

____

Poison Control Center: ______________________

Doctor: ______________________

____

Medical Society: ______________________

____

Area Hospitals: ______________________

____

____

Pharmacy: ______________________

Helpful Neighbors: ______________________

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*This and the following forms are from Operating Manual for Residential Services Personnel, 1974. V.F. Holland and R.F. Rubeck, eds. Nisonger Center for Mental Retardation and Developmental Disabilities.

MEDICAL SERVICES AND HOSPITAL EMERGENCY RELEASE

I, the undersigned, authorize the ______________________________
(name of school)
to secure medical services as they appear to be needed or in case of any apparent medical emergency involving ______________________________ .
(name of student)

I also hereby agree to be completely responsible for any fees or charges necessitated by medical services, medications rendered to or prescribed for the above named. I further understand that the ______________________________ will not be held responsible for medical
(name of school)
expenses incurred while the above named individual is participating in school programs.

In case of any apparent medical emergency, I, ____ bearing the relation of ________________________ to ______________________________ hereby give permission to the authorized physician in the hospital emergency room to perform the necessary treatment which will alleviate the emergency situation.

____
(Signature of parent or
Guardian)

(Witness)______________________________(Date)____________________

EMERGENCY PROCEDURES

I hereby give permission to ______________________________
(Name of school)
to initiate any/or all emergency procedures necessary for the health and safety of my child ______________________________
(Name)
during transportation to and from and during participation in the
____
(Name of school)
activities if I am not available to initiate the proceedings.

____
(Date) (Signature)

____
(Relationship)

INFORMATION REQUIRED FOR HOSPITAL ADMISSION

1. Legal name of child ______________________________
2. Address ______________________________
____
3. Parent's name ______________________________
Home Phone ______________________________
4. Date of birth of child ______________________________
5. Physician's name and address ______________________________
____
6. Father's place of employment ______________________________
____
Phone ______________________________
7. Name of insurance company covering the child ______________________________
____
8. Blue Cross Number ______________________________
Or Hospital Insurance Number ______________________________
9. Allergies ______________________________
10. Medication ______________________________
____

SECTION III

CASE HISTORIES

CASE HISTORIES

The three following case histories depict three children now in Arizona public schools. While all personally identifiable information has been removed, the case histories are accurate in showing how local schools provided services based on the unique needs of the three children. The three cases represent three major problem areas: Steven, medical; Richard, behavior; and Susan, placement. Each handicapped child entering the schools will present unique problems and will need a tailor-made plan (the IEP) to facilitate his or her education; the histories illustrate the types of solutions sought in three cases.

Case I - Steven

The case history of Steven, who was born July 4, 1966 at a metropolitan hospital in Arizona, illustrates some of the problems that can be presented by a student with severe medical problems. Steven's birth weight was 6 lb. 6 oz., and at three weeks of age, he began to have convulsions. He was diagnosed as hydrocephalic, and the doctors placed a right ventricular-peritoneal shunt; the seizures were myoclonic. Orthopedic evaluation revealed spastic diplegia was secondary to parencephaly.

Steven's latest psychological evaluations indicate distractibility, inattention, negative behavior, language skill at approximately the two-year level with response delays, perseveration and echolalia (severe expressive and receptive language delays). Audiometric screening indicated possible normal hearing range. Current performance on the Vineland Social Maturity Scale revealed a social age (SA) of 1.65. Peabody Picture Vocabulary Test performance indicated a mental age (MA) of 2.5. His current medication schedule includes 100 mg. of Dilantin and 30 mg. of phenobarbital.

Steven had been placed in an institution, but when the family moved to another Arizona city, they took Steven with them and enrolled him in public school.

Program Concerns

The following describes the provisions that were necessary in order for Steven to receive services in the public schools. While much of the equipment described was specifically needed for Steven, some of it was used by other children in the program. For example, a beanbag chair was procured for positioning Steven at certain times. This piece of equipment was also used by other children when it was not needed for Steven.

Due to varied medical problems, the school found it necessary to have oxygen available for emergency care while awaiting the arrival of the paramedics and/or the Fire Department's Rescue Squad. Posey belts for securing Steven were ordered and used in the classroom and a special seat belt was installed on the bus. A sized-helmet was ordered to protect him because seizuring is frequent and unpredictable. A cerebral palsy potty chair with a special seat insert was ordered. Plastic covered foam mats were necessary--one for diaper changing, the other for prone relaxation. Bibs, towels, wash cloths, nonallergenic soaps, lotions, and antibacterial creams are required to prevent tissue breakdown and infections. Nontoxic disinfectant liquids and spray bottles are imperative to control the spread of urinary and bowel tract infections. A washing machine, dryer, hot water heater, and nonallergenic washing compounds are required for washing the laundry generated by bathing, meal time and toileting. A modified diet includes nutritional supplements, e.g., extra-mild apple juice, etc., to reduce the frequency and severity of seizure activity; a modified school lunch, chosen to eliminate intestinal irritation, is chopped (grinder needed), served in a special scoop bowl and eaten with a specially designed spoon. To facilitate movement and increase sensory awareness, a "crawling turtle" was purchased.

A wheelchair was needed for Steven to use at school and at home. The school did not buy this; instead it became a project for the school nurse and social worker. They tapped the resources of five physicians at area clinics and hospitals; through their contributions a wheelchair was purchased.

The district is utilizing the following resource personnel for Steven: principal, supportive teacher, social worker, teacher, health clerk, classroom aides, school (pediatric) nurse, nurse practitioner, district physician, and therapists (occupational, physical and speech).

Case II - Richard

Richard was born on July 29, 1969. Like Steven, he has a history of seizure activity; his first seizure was also observed at three weeks of age. Richard has been medically diagnosed as suffering from a moderate hypotonic quadriplegic condition, and a diagnosis of Down's Syndrome has also been suggested. Psychological evaluations suggest that Richard functions within the severely deficient range of intellectual ability with concomitant delays observed in the areas of speech and language acquisition, motor control, and social-emotional development. Unlike Steven, however, Richard's primary problem involves behavior.

Richard is a physically attractive youngster who is small in height and weight for his age. Both auditory and visual acuity appear adequately developed as Richard did demonstrate a startle response to noxious auditory stimuli and he can visually track a dangling object. Motor control, both fine and gross, appear to be poorly developed and Richard's extremities are significantly involved, physically.

During the observation period, Richard was sprawled on the floor and had his right foot positioned very close to his mouth. He was unable to place a small ball in a box upon verbal command and he manipulated toys in a clumsy manner. Richard was able to propel himself across the floor in a "scooting" position, but was unable to crawl, stand, sit or walk without support. No expressive speech or vocalization of any type was observed during the evaluation session. Receptive language skills appeared equally underdeveloped as Richard was unable to consistently follow simple, one-step verbal directives. He was responsive to his name being called. Occasionally, Richard grasped a small toy and threw it across the floor. He played with objects in a rough, destructive manner and frequently attempted to take toys from other children. An adequate level of eye contact between Richard and the examiner could not be established and he was not readily responsive to verbal praise or encouragement. Thus, formal evaluation using standardized testing instruments was not accomplished.

Independent functioning in most basic self-help tasks appears severely impaired. Richard can feed himself with a spoon and drink from a cup. He is completely dependent upon adult assistance for dressing, undressing, bathing and toothbrushing. He has recently begun a program which is designed to encourage independence in removing his shirt, shoes and socks. He is not toilet conditioned and presently wears a diaper beneath his clothing. Motor control, both fine and gross, is poorly developed. Recently, Richard has begun to use an appropriate pincer grasp when manipulating toys, but such behavior is not observed on a consistent basis. Richard has been placed on a motor development program which is designed to enhance his ability to ambulate independently. At the present time, he can take several steps independently, but his gait is very awkward and clumsy. His motor development program also includes daily positioning at the "standing table" and efforts have been made to enhance his crawling skills and his ability to ride a modified tricycle. According to his teacher, Richard is progressing well in his motor development programs. He is, essentially, nonverbal as no intelligible speech or close word approximations have been observed. Receptive language is also severely impaired and physical guidance is employed on a routine basis in the classroom. Academic programs have been implemented in an effort to condition his attending skills and enhance his ability to follow one-step directions. Because of his severe physical handicaps, Richard's social interaction with agemates is limited. He frequently plays alone with a toy for ten to fifteen minutes, but seldom initiates cooperative play activities with others. Teacher reports indicate that Richard appears generally unaware of his environment, although he does seem to recognize familiar people. He is responsive to adult attention and approval and seems to enjoy one-to-one contact with an adult.

Richard is presently functioning within the profoundly deficient range of intellectual ability with significant handicapping conditions observed in the areas of physical development, motor control, speech and language acquisition, attention and concentration, social-emotional development and ability to independently perform most basic self-help tasks. Although no numerical value of intelligence was derived from this evaluation, it is estimated that such a value would fall well below twenty. In all developmental areas, Richard appears to be functioning within the twelve- to fifteen-month level. Because of the severity of his observed deficits, it appears he will not substantially increase his levels of cognitive or academic functioning. More promising educational goals appear to rest in the areas of enhancing Richard's motor control, providing him with some type of effective communication skills, and increasing his ability to independently perform basic self-help tasks. A small, highly structured and routine learning environment with frequent one-to-one interaction with an adult and plenty of opportunity for practice would seem ideal for him. Based upon the results of this evaluation, it appears likely that Richard will continue to require the close supervision, guidance and care of a responsible adult for many years to come.

With regard to an appropriate educational placement for Richard, it appeared likely that he could benefit substantially from a public school program which was designed to meet the needs of multiply handicapped, nonambulatory youngsters. And it was also suggested that Richard be considered for residential placement in a local group home which is specifically designed to serve multiply handicapped, nonambulatory youngsters.

Program Concerns

Richard was subsequently placed in the special public school program where he presented severe behavioral problems. Mainly Richard was super aggressive. He would often kick other children and staff; he would bite, pull hair and try to scratch other people's eyes. At one point he tried to strangle one of the other students.

This kind of behavior was disastrous in terms of the problems it created for the new program. Two staff members quit after they were seriously abused by Richard and it took about a month to replace them, thus impeding the development of the new program.

At one point Richard's aggression was so damaging that the local Arizona Training Program was asked to provide support in the form of a habilitation technologist and a psychologist for about two weeks to deal with Richard's behavior. Richard was then observed by them, and they made recommendations regarding his programming.

The following is a summary of the data collected over three days of observing Richard. Data were collected on ten-minute intervals and noted the number of times Richard aggressed, when staff interacted with him, how much time he engaged in self-stimulatory behavior, or was involved in unstructured individual or group activities. The initial summary is simply the number of ten-minute blocks in which one or more of the variables were noted. It does not indicate the rate within a block or the duration.

Number of ten-minute blocks

	October 2	October 3	October 4
Unstructured time - no attention	11	10	12
No attention except response to aggression	4	1	6
Staff attention unrelated to aggression	8	10	9
Staff attention prior to aggression	-	2	5
Aggression	10	4	9
Group activities	2	-	-
Self-stimulatory	13	14	10
Individual activities	6 +Lunch	Lunch	3 +Lunch

Two major hypotheses regarding Richard's aggression behavior were formulated before data collection was begun. The first was that he aggressed for staff attention; the second, that he aggressed in response to or because of staff attention--in other words, to escape staff attention. The data do not support either hypothesis; the data are simply not sufficient.

It had also been postulated that Richard reacts aggressively when he wets/soils his pants and goes unattended. There were three noted incidents of aggression occuring when Richard was wet/soiled, either as he was being changed, or before he was changed: once when a staff member was interacting with other students while Richard was near, once right after a staff member interacted with other students while Richard was near, and the third time right after the staff member had been interacting with Richard. On both days, there were two major incidents of aggression (wherein Richard made contact with two or more people).

As stated earlier, nothing conclusive can be drawn from the data regarding staff attention and Richard's aggressions.

One major situation noted in the data was long periods when Richard was in unstructured time and during which he engaged in self-stimulatory type behaviors and also received little staff attention.

The two professionals made the following recommendations for Richard's program. They are basic procedures which they felt, when properly initiated, should affect his behavior.

1. Richard should be given staff attention paired with some consumable reinforcer every five to seven minutes. It is important that the attention is given this often and that it is paired with the consumable if either hypothesis is true. If his aggression is a reaction to staff attention, there is the need to develop the attention as a reinforcer by pairing it with consumables he likes. If it is, indeed, for attention, there is the need to reinforce him often initially while he is taught other skills. This would be basically a differential reinforcement of other behavior, wherein Richard would be reinforced for any nonaggressive prosocial behaviors, ideally while he is not self-stimulating.

2. Richard should have less unstructured, unattended time. He will need more structured one-on-one or group activities that teach him some functional or building skills. These programs should be centered around meaningful activities.

3. "Time out" seems contraindicated as a method of dealing with his aggression. If he is reacting to attention by aggressing, "time out" might serve as a reinforcer. Some other method should be devised to diminish his aggressions.

4. Efforts should be made to form some barrier between Richard and other students for a while. A staff member could try to always be situated between Richard and other students during unstructured and structured times.

5. When Richard aggresses, he should be dealt with in as neutral a manner as possible with little verbal interaction--possibly just a firm "No, Richard." If he is aggressing against a student, he will need to be removed from the immediate area of the student. If he is aggressing against a staff member, his movements should be blocked when possible, and when possible, he should be completely ignored after that. When he ceases to aggress, a brief interval should follow which is then followed by social attention paired with a consumable, especially if Richard is engaged in a somewhat constructive activity. He may even need to be guided through some activities.

Variations of these recommendations were implemented and Richard seems to have responded. His behavior is under control and his program is progressing.

Case III - Susan

Susan was born on January 1, 1969.

Physical examination reveals that Susan walks with an overactive posterior tibial tendon. She has an unsteady gait; abduction is to 60 degrees. There is inability to dorsiflex the leg at 70 degrees with spastic hamstrings. The heel cord can be brought up above the right ankle indicating only spasticity. The posterior tibial tendon is rather spastic. The left upper arm is spongy in effect. The hips can be hyperextended on either side. There is a pes plantus, bilaterally. The left foot is internally rotated, the right is externally rotated. Both her heels are in severe valgus. The forefoot is inverted on the left and everted on the right.

Susan should have a calcaneal osteotomy bilaterally and on admission to the hospital should have an x-ray of the pelvis and both feet. She has cerebral palsy which may be of the athetoid type. There is a possibility that Susan may be microcephalic due to reduced cranial circumference (past history of seizures and in 1970 her head circumference was three standard deviations below normal). Fine motor skills are lacking. She seems to have many perseverative tendencies. Susan appears to have difficulty in figure-ground relationships. She appears to have definite motor awkwardness which may be a contributing factor in her social incompetence. Emotional lability does not seem to be an important factor here. Susan does not seem to think in an abstract manner and seems to show signs of conceptual rigidity.

Susan's expressions show she is more aware of the children than are the other children in her group, and she shows more of an interest in what they are doing. She seems happy and is much more alert as to what is going on around her. She is well liked by all her peer group.

Susan is nearly always even-tempered and friendly. She has nearly eliminated the habit of whining, and will go willingly from one activity to another when directed by the teacher.

Susan's attention span is increasing and she will sit quietly and listen at story time. She enjoys music and tries to use the instruments and will clap her hands to the rhythm. She needs guidance in all art work. She likes to put the weather signs on the calendar and the objects that go with the story on the flannel board; she also likes to look at story books and is turning the pages much better.

Susan is walking much better and falling less often. She can seat herself at the table, but needs to sit back in a chair with a straight back because she has a tendency to slump down while sitting. She can walk up and down steps, but will only do so if the teacher insists. Her pincer grasp is developing much better.

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Susan will climb up on the stool to wash her face and hands without assistance, but she needs complete supervision in the toilet routine. She seems to know what the potty chair is for and, if taken frequently, she can be kept dry most of the day. She sometimes tries to help in dressing by extending her arms and feet if she has support. Susan uses her glass and spoon well, but wants to put more food into her mouth before swallowing. Although this is improving, she is still quite a messy eater.

Program Concerns

Susan resides at a foster group home, and attends a public school. Her mother lives 120 miles away from the school, but has retained responsibility for decisions regarding placement, the IEP, etc. This has created a number of scheduling problems as plans must be made around her mother's presence in town.

Susan presents a number of problems. First, she is difficult to test. She is cute and well-dressed, thus everyone is surprised by her poor test results and assumes that she must really be smarter. This, of course, may not be the case and it is confusing to those working with her. This is especially true in light of her parroting behavior. She uses verbal expressions which are far above her level; she does not understand them, she merely repeats them, generally inappropriately.

The second major problem is that she has had orthopedic surgery four times, putting her into and out of casts and into a wheelchair with a a leg extension. This created a real dilemma in her placement. It was thought she could benefit greatly from the intensive stimulation she would receive in a trainable mentally handicapped class, especially in the language area. Yet she needed more physical care than was available in the TMH class. For example, she could not go to the bathroom herself nor could she go to the playground.

A split placement was tried but this was very confusing to Susan, so for awhile she met with two TMH children for language training while remaining in the multiply handicapped class. Eventually she became part of a small class of higher functioning multiply handicapped children.

As placement changes seemed appropriate, one of two things would usually happen: Susuan would either regress to where she wasn't benefiting or she would need surgery, thus requiring extra physical care. Each time it was if she were trying to thwart her placement. She also needed a special bus for transportation following each surgery.

Experience also indicated it was necessary to have the school physical therapist attend staffings at the hospital to find out what type of physical therapy Susan would require in school after her surgery. This was due to the three weeks it took to get this information through normal channels. Of course, this required parental permission which, due to the distance, was time consuming.

Susan seems to be benefiting from her current placement but regression is not uncommon.

APPENDIX A

ELIGIBILITY FOR
BUREAU OF MENTAL RETARDATION SERVICES

ARTICLE 3

ELIGIBILITY FOR BUREAU OF MENTAL RETARDATION SERVICES

R6-6-301

The word "Bureau" means the Bureau of Mental Retardation of the State Department of Economic Security.

The term "mental retardation" means a condition involving subaverage general intellectual functioning and exists concurrently with deficits in adaptive behavior which is or was mainifested before age 18.

The term "significantly subaverage general intellectual functioning" refers to performance which is two or more standard deviations from the mean or average of a test measuring intellectual functioning.

The term "deficits in adaptive behavior" refers to a person not meeting the standards of personal independence and social responsibility expected of his/her age and cultural group.

R6-6-302

In order to be eligible for Bureau services a person must be mentally retarded as determined in accordance with R6-6-303 and must be a resident of the state of Arizona.

R6-6-303

Significantly subaverage general intellectual functioning shall be determined by standardized tests recognized as being valid for measuring intellectual functioning, such as the Stanford-Binet and Wechsler.

Deficits in adaptive behavior shall be determined by standardized scales generally recognized as being valid for measuring adaptive behavior, such as the Adaptive Behavior Scale and the Vineland.

Expectations for a person's adaptive behavior vary for different age groups, therefore deficits in adaptive behavior vary at different ages.

During infancy and early childhood adaptive behavior measurements include sensory-motor skills development, communication skills, self-help skills, and socialization. During childhood and early adolescence it includes application of basic academic skills in daily life activities, application of appropriate reasoning and judgment in mastery of the environment, and social skills. In late adolescence and adult life it includes vocational and social responsibilities and performances.

The Bureau recognizes the difficulty of accurately assessing intellectual functioning of young infants and children. For this reason, children between the ages of 0-3 will be determined eligible according to a standardized developmental scale which indicates a developmental delay in the child in relationship to his peers and a high risk which will likely result in mental retardation in later years, such as a genetic factor linked to mental retardation.

Where diagnosis of mental retardation is uncertain, qualified consultation including an appropriately certified psychologist and/or psychiatrist may be obtained at Bureau discretion or a special review will be conducted by Bureau staff. Such consultation or review shall analyze the social history and/or past evaluations of the individual to ascertain if the cause of the individual's significantly subaverage general intellectual functioning is the manifestation of mental retardation or some other problem such as mental illness, severe sensory impairment, autism or other complex disabilities.

Final determination of eligibility will be the decision of the Bureau.

APPENDIX B

PLACEMENT INTO SERVICES FROM THE COMMUNITY

PLACEMENT INTO SERVICES FROM THE COMMUNITY

There is a central point of intake for each of the BMR's service districts; this is the Resource Services Division, Case Management. Each district operates under the same statewide policies. A district may have a centralized intake unit (such as Phoenix and Tucson) or have case managers in various geographic locations who perform the function of intake. Page 5 lists offices where intake staff are located across the state.

If a mentally retarded person or family with a mentally retarded child in the community is seeking services, they contact this intake unit by phone or in person. If the referral is simply for services which might be needed and located outside of the BMR service system, information on these services is given so that the family may locate services. After a few weeks the intake worker will call back to ensure the family/person has located services and request if they need further assistance from BMR (i.e. case manager).

If existing services are not easily located or available, the BMR will assess the person's needs and determine if he/she is eligible for BMR services (i.e. mentally retarded and a resident of the state). As a person is determined eligible and the assessment/evaluation of needs is completed, the case manager will go to the appropriate district division director of services needed by the applicant (Residential, Adult, Child, Resource). These division directors then become responsible for developing services for the individual. This is primarily done by buying a "unit of service" from a community program if money is available. If resources are not available the person would be put on a waiting list until a person in services moves to another setting. In some cases, such as residential services, reserve amounts of monies are held back for emergency cases to create special alternatives for those in "crisis" situations. In other cases, if the need is of a "crisis" nature, the division director(s) can be flexible and creative with all existing resources.

Within 30 days after the person is placed in services, the case manager for the person organizes the team of people working with the client (including the parent and client) to develop an Individual Program Plan for the client. The IPP is a written statement of habilitative and therapeutic goals and objectives established for an individual client. It acts as a "contract" for specific services the client is to receive. After this IPP is written and agreed to by members of the team, the case manager then follows-up on client services to ensure the client is getting services agreed upon.

APPENDIX C

BUREAU OF MENTAL RETARDATION
ORGANIZATIONAL STRUCTURE AND MAP

BUREAU OF MENTAL RETARDATION* ORGANIZATIONAL STRUCTURE AND MAP

The Bureau of Mental Retardation currently operates under an organizational structure which manages community and Arizona Training Program Services as one system. This concept is extremely important as a vehicle for each service area (Residential, Child, Adult, and Resource Services) to develop its own service continuum to meet the wide variety of individual needs for mentally retarded persons in Arizona.

The basic management of the Bureau of Mental Retardation is described by the following information; each district is organized in a similar manner with similar service responsibilities, thus offering coordination efforts between districts for cases when districts must work together to develop services for particular clients.

In summary:

BMR STATE OFFICE: directs and manages all BMR services through program planning, management of districts, and developing statewide program policy, direction and coordination.

BMR DISTRICT PROGRAM MANAGERS: responsible for planning, developing and managing services for mentally retarded persons in their districts.

DISTRICT RESIDENTIAL DIVISION DIRECTORS: responsible for planning, developing and managing services for those mentally retarded persons in their districts in need of residential services. This includes residential services at the Arizona Training Program in the district as well as in community residential programs.

DISTRICT CHILDREN SERVICES DIVISION DIRECTORS: responsible for planning, developing and managing educational and training programs for children during the day. This includes working with the public school programs, operating special education programs at the Arizona Training Program, and developing and managing infant stimulation and preschool programs for mentally retarded children in the districts.

DISTRICT ADULT SERVICES DIVISION DIRECTORS: responsible for planning, developing and managing day training programs for adult mentally retarded persons in their districts. This includes programs at the Arizona Training Program as well as those in the communities.

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*Now Division of Developmental Disabilities/Mental Retardation. Organizational structures and responsibilities remain the same.

RESOURCE SERVICES DIVISION DIRECTORS: responsible for training staff of the district; providing support services such as speech, physical and occupational therapy and in-home services; provide a central intake system for mentally retarded persons in the district to enter BMR services and provide the coordination and direct monitoring of client programs through the Individual Program Plan for each client.

With such a concept of organizational structure, the district managers are the HUB of services for mentally retarded persons throughout each district.

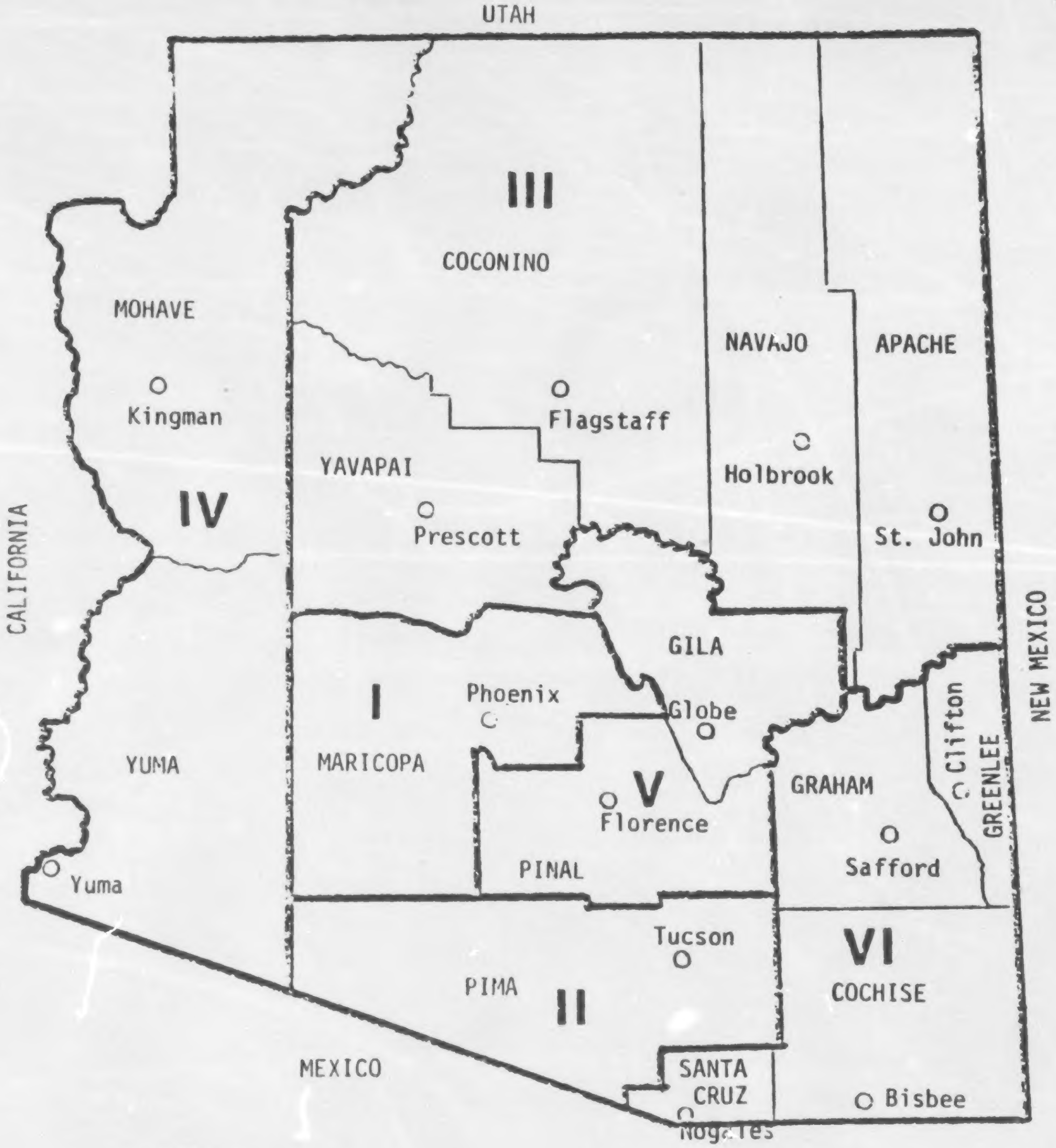
ATPP - I

ATPC - V

ATPT - II

State of Arizona
Bureau of Mental Retardation

STATE PLANNING AND DEVELOPMENT DISTRICTS


UTAH
III
COCONINO
MOHAVE
NAVAJO
APACHE
Kingman
Flagstaff
Holbrook
YAVAPAI
IV
Prescott
St. John
CALIFORNIA
NEW MEXICO
GILA
I
Phoenix
Globe
MARICOPA
YUMA
Clifton
V
GRAHAM
GREENLEE
Florence
Safford
Yuma
PINAL
Tucson
VI
PIMA
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COCHISE
MEXICO
SANTA CRUZ
Bisbee
Nogales

ARIZONA

partment of Economic Planning and Development

District Perimeter —
County Perimeter —
County Seat ○

12/77

APPENDIX D

SUPPLEMENTAL SECURITY INCOME
DISABLED CHILDREN'S PROGRAM

SUPPLEMENTAL SECURITY INCOME-DISABLED CHILDREN'S PROGRAM

The Supplemental Security Income (SSI) Disabled Children's Program is a federally funded program administered by Arizona's Department of Health Services, Bureau of Child Development, 200 No. Curry Rd., Tempe, Arizona 85281. Telephone 244-9471, ext. 273.

To be eligible a child must:

1. be blind or disabled;
2. receive Supplemental Security Income benefits; and,
3. be under age sixteen.

The purpose of the SSI-Disabled Children's Program is to assess the total needs of the disabled child and to ensure that all the services necessary to meet the child's needs are provided.

For SSI children who are under the age seven or who are not attending public school, the program may pay for some needed services for which no other funds are available. For SSI children over the age of seven and in public school, the program will provide referrals to needed services.

The following will help to answer questions you may have about the program.

Q. How can a child receive SSI-Disabled Children's Program services?

A. The child must be eligible for services and referred by the Arizona Disability Determination Unit, Division of Employment and Rehabilitation Services.

Q. After a child's name is referred to the program what happens?

A. A member of the SSI team will contact the child's parents or guardian to explain the program and ask if they are interested in receiving services.

Q. How will the local SSI team know what the child's needs are?

A. Needs will be determined from talking with the parents, and from professional assessments. The professional assessments could be medical, social, vocational, developmental, educational or nutritional, depending on the child's particular problem.

Q. Can a parent appeal decisions about a child's services?

A. Yes, if a parent disagrees with a decision or action of the

SSI team, the parent should contact the SSI Coordinator in person, by letter, or by phone and state the problem.

Q. Is information about the child confidential?

A. Yes, such information will be given only to those agencies and professionals who are providing services to the child and only with the parents' or guardian's permission.

Q. How is it determined what services a child should receive?

A. After determining the child's particular needs, the team, and possibly other professionals, will write a plan for the child, called the Individual Service Plan. This plan will state goals for the child, the services needed to meet these goals, and who will provide the service.

Q. What happens after the plan is written?

A. A team member will discuss the plan with the family and refer them to the services on the plan. If the parent disagrees with any part of the child's plan, the plan may be changed.

At some later date, the team member will check to see if the child is receiving the services, if they are appropriate, and if they are accomplishing what they should.

Q. Can the SSI-Disabled Children's Program pay for some of the services in the Plan?

A. Yes, if the child is under age seven and not in public school.

Q. What happens when a child becomes seven years old or goes off SSI?

A. The SSI-Disabled Children's Program may provide services for a brief period if necessary after the child reaches seven or goes off SSI. In either case, referrals will be made to ensure that services continue.

APPENDIX E

ARIONZA HOUSE BILL 2426/ARS 14-15

adopted by the 1978
Arizona State Legislature
and incorporated into
the Arizona Revised Statutes

COMPILED AND ISSUED BY
ROSE MOFFORD
SECRETARY OF STATE
for use until Session Laws are printed

State of Arizona
House of Representatives
Thirty-third Legislature
Second Regular Session
1978

CHAPTER 198

HOUSE BILL 2426

AN ACT

RELATING TO MENTAL RETARDATION; PROVIDING FOR COURT ASSIGNMENT OF MENTALLY RETARDED CHILDREN; PRESCRIBING FOSTER PLACEMENT OF MENTALLY RETARDED CHILDREN; PROVIDING FOR CERTIFICATES OF EDUCATIONAL CONVENIENCE; PRESCRIBING SPECIAL EDUCATION AND SERVICES TO SCHOOL-AGE MENTALLY RETARDED PERSONS BY SCHOOL DISTRICTS; PRESCRIBING REPORTS; PROVIDING FOR COORDINATION OF VOCATIONAL REHABILITATION SERVICES; PRESCRIBING DUTIES OF DEPARTMENT OF HEALTH SERVICES FOR MENTALLY RETARDED PERSONS ASSIGNED TO THE STATE HOSPITAL; PROVIDING FOR STATE PROGRAMS AND SERVICES FOR MENTALLY RETARDED PERSONS PROVIDED BY THE DEPARTMENT OF ECONOMIC SECURITY; PROVIDING DEFINITIONS; PROVIDING FOR RECOGNITION AND PROTECTION OF THE INDIVIDUAL RIGHTS OF MENTALLY RETARDED PERSONS; PRESCRIBING DUTIES AND MEMBERSHIP OF MENTAL RETARDATION ADVISORY COUNCIL; PRESCRIBING DUTIES OF DIRECTOR OF DEPARTMENT OF ECONOMIC SECURITY TO DEVELOP AND INITIATE SPECIFIED MENTAL RETARDATION PROGRAMS AND SERVICES; PROVIDING FOR COORDINATION BY THE DEPARTMENT OF ECONOMIC SECURITY PROGRAMS AND SERVICES WITH SCHOOL DISTRICTS; PROVIDING FOR PURCHASE OF COMMUNITY MENTAL RETARDATION SERVICES; PROVIDING THAT THE DEPARTMENT OF ECONOMIC SECURITY SHALL COORDINATE ITS OPERATIONS WITH THE DEPARTMENT OF HEALTH SERVICES; PRESCRIBING SERVICES WHICH MAY BE PROVIDED BY THE BUREAU; PROVIDING FOR OPERATION, SUPPORT AND SUPERVISION OF SPECIAL FOSTER HOMES FOR MENTALLY RETARDED CHILDREN; PRESCRIBING ELIGIBILITY FOR MENTAL RETARDATION PROGRAMS AND SERVICES; PRESCRIBING PROCEDURES FOR ADMISSION TO STATE-OPERATED OR STATE-FUNDED PROGRAMS AND SERVICES; PROVIDING FOR AVERSIVE STIMULI AND PROHIBITING CERTAIN TREATMENT AND DRUGS; PRESCRIBING SCHEDULE OF FINANCIAL CONTRIBUTIONS BY MENTALLY RETARDED PERSONS AND BY COUNTIES FOR MENTAL RETARDATION PROGRAMS AND SERVICES; PRESCRIBING BILLING PROCEDURES; PRESCRIBING REVIEW AND APPEAL PROCEDURES; PRESCRIBING REQUIREMENT FOR GUARDIANSHIP; PROVIDING FOR PERIODIC EVALUATIONS OF MENTALLY RETARDED PERSONS; PRESCRIBING METHODS OF TERMINATION FROM MENTAL RETARDATION PROGRAMS AND SERVICES; PROVIDING FOR EXCLUSION OF COUNTY CHARGES FOR CLIENTS RECEIVING RESIDENTIAL SERVICES FROM BUDGET AND TAX LIMITATIONS; PROVIDING FOR CONFIDENTIALITY OF RECORDS; PRESCRIBING VIOLATIONS; PROVIDING FOR EXCLUSION OF PAYMENT FOR CERTAIN MENTAL RETARDATION SERVICES FROM COUNTY

BUDGETS; PROVIDING DEFINITIONS AND THAT RESIDENTIAL FACILITIES SHALL RECEIVE CERTAIN ZONING TREATMENT AND RESTRICTIONS; PROVIDING FOR MAINTENANCE IN SEPARATE ACCOUNTS OF MONIES FOR USE FOR MENTAL RETARDATION; PROVIDING FOR TESTS FOR METABOLIC DISORDERS; PROVIDING FOR ADMISSIONS UNDER PRIOR LAW; PROVIDING A DEDUCTION FOR INCOME TAX PURPOSES; AMENDING SECTIONS 8-242 AND 8-514, ARIZONA REVISED STATUTES; AMENDING TITLE 8, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 8-514.01; AMENDING SECTIONS 15-304, 15-1013 AND 15-1015, ARIZONA REVISED STATUTES; AMENDING TITLE 15, CHAPTER 10, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 15-1015.02; AMENDING TITLE 23, CHAPTER 3, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 23-503.01; AMENDING TITLE 36, CHAPTER 2, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-203; AMENDING SECTIONS 36-551 THROUGH 36-554, 36-557 THROUGH 36-559, 36-562, 36-568, 36-569, 36-571 AND 36-694, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 5.1, ARTICLE 1, BY ADDING SECTIONS 36-551.01, 36-554.01, 36-554.02, 36-558.01, 36-560, 36-561, 36-563 THROUGH 36-566 AND 36-568.01, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 5.1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 2; AMENDING TITLE 43, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 43-123.47, AND REPEALING SECTIONS 36-556, 36-560, 36-561, 36-563 THROUGH 36-567 AND 36-570, ARIZONA REVISED STATUTES.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Legislative intent

It is the public policy of this state that the state:

1. Provide, subject to available funds, a wide variety of services to mentally retarded persons admitted to state-operated services or programs which respond to the differing needs and abilities of such persons.

2. Provide services which will permit families to maintain mentally retarded persons in their own homes.

3. Recognize by statute the legal rights of mentally retarded persons.

4. Coordinate the delivery of programs and services to mentally retarded persons by the public agencies providing such programs and services.

5. Provide for each person admitted to state-operated mental retardation services and programs an individual program plan for such persons.

Sec. 2. Section 8-242, Arizona Revised Statutes, is amended to read:

8-242. Disposition of mentally ill or mentally retarded child

A. If, at a dispositional hearing of a child adjudged to be delinquent, dependent or incorrigible, or prior thereto, the evidence indicates that the child may be suffering from mental retardation or mental illness, the juvenile court before making a disposition shall order such study and report on the child's mental condition as the court determines is necessary.

B. If it appears from the study and the report that the child is mentally ill or mentally retarded, the juvenile court shall hear the matter, and if the child is found:

1. To be committable under the laws of this state AS MENTALLY ILL, the juvenile court shall order the child committed to the appropriate institution for the mentally ill. ~~or mentally retarded,~~

2. TO BE MENTALLY RETARDED, SUCH CHILD SHALL BE ASSIGNED BY THE JUVENILE COURT PURSUANT TO SECTION 8-241. IF A MENTALLY RETARDED CHILD IS ASSIGNED BY THE JUVENILE COURT TO THE DEPARTMENT OF ECONOMIC SECURITY, SUCH ASSIGNMENT SHALL BE SUBJECT TO THE PROVISIONS OF SECTION 36-560.

C. If it appears from the study and report or hearing that the child is not committable as a mentally ill CHILD or SUBJECT TO ASSIGNMENT AS A mentally retarded child, the juvenile court shall proceed in the manner as otherwise provided by this chapter.

Sec. 3. Section 8-514, Arizona Revised Statutes, is amended to read:

8-514. Placement in foster homes

A. SUBJECT TO THE PROVISIONS OF SECTION 8-514.01, the division or a licensed child welfare agency if so authorized in its license, may place a child in a licensed foster home for care or for adoption.

B. At the time of placement there shall be presented to the foster parents, by the agency or division placing the child, a written summary of known, unprivileged, information regarding the child, including but not limited to:

1. Demographic information.
2. Type of custody and previous placement.
3. Pertinent family information including but not limited to the names of family members who, by court order, may not visit the child.
4. Known or available medical history including but not limited to:
   (a) Allergies.
   (b) Immunizations.
   (c) Childhood diseases.
   (d) Physical handicaps.
   (e) Other idiosyncrasies.
   (f) The child's last doctor, if known.
5. A summary of the child's history of adjudication on acts of delinquency, as may be public record and available in the file of the clerk of the superior court.

C. The responsibility of the agency or the division for a child placed in a foster home shall be defined in writing and accepted by the person receiving the child. The agency or division shall make available to the foster parents a method of acquiring emergency information that may be necessary to deal with situations that may arise pursuant to their responsibilities as foster parents.

D. Every foster home shall maintain a record of the children received, which shall include facts in regard to the children and their care and shall be in the form and kept in the manner prescribed by the division.

Sec. 4. Title 8, chapter 5, article 1, Arizona Revised Statutes, is amended by adding section 8-514.01, to read:

8-514.01. Placement of mentally retarded children

ALL FOSTER PLACEMENTS OF MENTALLY RETARDED CHILDREN MADE BY THE DIVISION SHALL BE MADE TO SPECIAL FOSTER HOMES FOR MENTALLY RETARDED CHILDREN OPERATED OR LICENSED BY THE DIVISION WHICH PROVIDE SPECIALIZED PROGRAMS FOR MENTALLY RETARDED CHILDREN, EXCEPT THAT PLACEMENTS OF MENTALLY RETARDED CHILDREN TO OTHER TYPES OF FOSTER HOMES MAY BE MADE, WHEN THE DIVISION DETERMINES THAT SUCH PLACEMENT IS IN THE BEST INTERESTS OF THE CHILD, WHEN SPACE IS NOT AVAILABLE IN SUCH A SPECIAL FOSTER HOME OR WHEN TWO OR MORE CHILDREN OF THE SAME FAMILY ARE INVOLVED IN FOSTER CARE PLACEMENTS AND THE DIVISION FINDS THAT PLACEMENT IN THE SAME FOSTER HOME, OTHER THAN SUCH A SPECIAL FOSTER HOME IS IN THE BEST INTERESTS OF THE CHILDREN.

Sec. 5. Section 15-304, Arizona Revised Statutes, is amended to read:

15-304. Certificate of educational convenience; issuance; effect on membership records

A. A pupil precluded by distance or lack of adequate transportation facilities from attending a common or high school in the district or county of his residence or who resides in unorganized territory may apply to the county school superintendent for a certificate of educational convenience. If it appears to the superintendent that it is not feasible for the pupil to attend the common or high school in the district or county of residence, he shall issue a certificate authorizing the pupil to attend a common or high school in an adjoining district or county, whether within or without the state.

1. The school membership of a pupil precluded from attending a school in the district or county of his residence, when certified to the county superintendent by the official in charge of the school attended, shall be deemed for the purpose of determining average daily membership to be membership in the common or high school of the county or district of the student's residence.

2. The school membership of a pupil from unorganized territory shall be deemed for the purpose of determining average daily membership to be membership in the common or high school district of actual attendance.

B. The county school superintendent of any county in which a pupil is placed as described in paragraph 1, 2, ~~or~~ 3 OR 4 of this subsection shall issue a certificate of educational convenience for the pupil to attend school in the school district or adjoining school district to that in which the pupil is placed in one of the following:

1. A state rehabilitation or corrective institution.

2. A foster home or child care agency or institution which is licensed and supervised by the state department of economic security.

3. A RESIDENTIAL FACILITY OPERATED OR SUPPORTED BY THE DEPARTMENT OF ECONOMIC SECURITY IN A DISTRICT OTHER THAN A DISTRICT IN WHICH THE PARENT OF THE PUPIL RESIDES.

~~3.~~ 4. Under the supervision of the department of corrections in a residence pursuant to the interstate compact on juveniles.

C. If a certificate of convenience is issued as provided by the terms of subsection B the school membership of such pupil shall be deemed, for the purpose of determining average daily membership, to be membership in the common or high school of the district of actual attendance. Tuition may be charged the state superintendent of public instruction by the district of actual attendance as for nonresident attendance, provided that the per capita apportionment of state aid shall be deducted from the total amount charged for tuition. The county school superintendent issuing a certificate shall notify the state superintendent of the issuance. The state superintendent shall draw a warrant upon the state treasurer in favor of the school of actual attendance for the amount charged as adjusted, whether for common or high school attendance, in conformity with the provisions of section 15-449. EXPENDITURES BY A SCHOOL DISTRICT ATTRIBUTABLE TO A PUPIL PLACED AS DESCRIBED IN SUBSECTION B, IN A DISTRICT OTHER THAN THE DISTRICT IN WHICH THE PARENT OF THE PUPIL RESIDES, SHALL BE EXEMPT FROM THE ALLOWABLE BUDGET LIMIT FOR THE SPECIAL EDUCATION PORTION OF THE DISTRICT BUDGET, AS DETERMINED IN SECTION 15-1017, IN THE AMOUNT THAT FUNDS ARE RECEIVED BY THE DISTRICT FROM A CERTIFICATE OF EDUCATIONAL CONVENIENCE ISSUED PURSUANT TO SUBSECTION B OF THIS SECTION OR A SPECIAL EDUCATION INSTITUTIONAL VOUCHER, ISSUED PURSUANT TO CHAPTER 17, ARTICLE 1 OF THIS TITLE ISSUED FOR SUCH A PUPIL.

Sec. 6. Section 15-1013, Arizona Revised Statutes, is amended to read:

15-1013. Evaluation of child for placement in special education program

A. The referral of a child for evaluation for possible placement in a special education program shall be made under the direction of the chief administrative official of the school district or county, or such person designated by him as responsible for special education, after consultation with the parent or guardian.

B. Before a child is placed in a special education program an evaluation shall be made of the capabilities and limitations of the child. The evaluation shall be made by at least one professional specialist in a field relevant to the child's handicap and under the direction of the chief administrative official of the school district or county or such person designated by him as responsible for special education. If appropriate, the educational implications of the handicapping conditions shall be evaluated by a psychologist. THE DISTRICT MAY CONDUCT JOINTLY, DIRECTLY OR INDIRECTLY, WITH THE DEPARTMENT OF ECONOMIC SECURITY THE SPECIAL EDUCATION EVALUATION OF A HANDICAPPED PUPIL ENROLLED IN THE DISTRICT WHO HAS APPLIED FOR OR IS RECEIVING MENTAL RETARDATION PROGRAMS OR SERVICES FROM THE DEPARTMENT OF ECONOMIC SECURITY OR MAY CONTRACT WITH THE DEPARTMENT OF ECONOMIC SECURITY TO PROVIDE A PLACEMENT EVALUATION FOR THE DEPARTMENT OF ECONOMIC SECURITY OR TO HAVE THE DEPARTMENT OF ECONOMIC SECURITY PROVIDE THE SPECIAL EDUCATION EVALUATION FOR THE DISTRICT. The evaluation pursuant to this section shall contain in writing, but is not limited to:

1. Reason for referral.

2. Educationally relevant medical findings.

3. Educational history of the child including complete documentation of efforts to educate the child in the regular classroom.

4. Determination whether the child's educational problems are related to or resulting from reasons of educational disadvantage.

5. Developmental history of the child.

6. Types of tests administered to the child and results of such tests.

7. Recommendation of specific goals and instructional objectives based upon current levels of performance needs.

C. The results of the evaluation shall be submitted in writing and with recommendations to the chief administrative official of the school district or county or to such person designated by him as responsible for special education.

D. In determining placement the following persons shall be consulted by the chief administrative official of the school district or county or such person designated by him as responsible for special education:

1. The school principal.

2. A person responsible for administering or conducting special education courses in the school or school district and a special education teacher who may provide the special services designed for the child.

3. A teacher who currently has been instructing the child.

4. An appropriate professional adviser who may be a physician, psychologist, professional social worker or school nurse.

5. A parent or guardian of the child.

E. The chief administrative official of the school district or county or such person designated by him as responsible for special education shall place the child, except that no child shall be placed or retained in a special education program without the approval of his parent or guardian.

Sec. 7. Section 15-1015, Arizona Revised Statutes, is amended to read:

15-1015. Powers of the governing board of a school district or county

A. The governing board of each school district or the county school superintendent shall by the school year 1976-1977:

1. Provide special education and required supportive services for all handicapped, except seriously emotionally handicapped, children. The governing board of each school district or the county school superintendent shall by the school year 1978-1979 provide special education and required supportive services for seriously emotionally handicapped children.

2. Employ supportive special personnel, which may include a director of special education, for the operation of special school programs for exceptional children.

3. To the extent practicable, educate handicapped children in the regular education classes. Special classes, separate schooling or other removal of handicapped children from the regular educational environment, shall occur only if, and to the extent that the nature or severity of the handicap is such that education in regular classes, even with the use of supplementary aids and services, cannot be accomplished satisfactorily.

4. Provide necessary transportation for handicapped children in connection with any program, class or service.

5. Establish district policy with regard to allowable pupil-teacher ratios and pupil-staff ratios within the district for provision of special education services.

B. The special education program established pursuant to this section shall be conducted only in a school facility which houses regular education classes or in other facilities approved by the state division of special education.

C. For the purposes of this section, handicapped children being furnished special education in rehabilitation, corrective or other state and county supported institutions shall be the responsibility of that institution or facility. Special education programs at such institution or facility shall conform to the conditions and standards prescribed by the director of the division of special education.

D. NOTWITHSTANDING THE PROVISIONS OF SUBSECTION C, THE DEPARTMENT OF ECONOMIC SECURITY MAY REQUEST ON BEHALF OF A SCHOOL AGED HANDICAPPED CHILD RESIDING IN A RESIDENTIAL FACILITY OPERATED OR SUPPORTED BY THE DEPARTMENT OF ECONOMIC SECURITY OR IN A SPECIAL FOSTER HOME FOR MENTALLY RETARDED PERSONS AS DESCRIBED IN SECTION 36-558.01 THAT THE SCHOOL DISTRICT IN WHICH SUCH FACILITY OR HOME IS LOCATED ENROLL SUCH SCHOOL AGED CHILD IN THE DISTRICT. SUCH SCHOOL DISTRICT SHALL, UPON SUCH REQUEST BY THE DEPARTMENT OF ECONOMIC SECURITY, ENROLL SUCH HANDICAPPED CHILD AND PROVIDE SPECIAL EDUCATION AND RELATED SUPPORTIVE SERVICES TO SUCH CHILD, SUBJECT TO THE PROVISIONS OF SECTION 15-304 OR CHAPTER 17, ARTICLE 1 OF THIS TITLE. A SCHOOL DISTRICT IN WHICH A HANDICAPPED CHILD IS ENROLLED SHALL COORDINATE THE DEVELOPMENT OF AN INDIVIDUAL EDUCATION PROGRAM PLAN WITH THE DEPARTMENT OF ECONOMIC SECURITY'S DEVELOPMENT OF AN INDIVIDUAL PLAN FOR SUCH CHILD WHEN SUCH CHILD HAS APPLIED FOR OR IS RECEIVING MENTAL RETARDATION PROGRAMS AND SERVICES PROVIDED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT OF ECONOMIC SECURITY. THE PROVISION OF SPECIAL EDUCATION AND SUPPORTIVE SERVICES TO SUCH CHILD MAY BE SUBJECT TO THE PROVISIONS OF SUBSECTION F OF THIS SECTION.

~~D.~~ E. The governing body of each common or high school district, county or agencies involved in intergovernmental agreements may:

1. In cooperation with another district or districts, establish special education programs for exceptional children. When two or more governing bodies determine to carry out by joint agreement the duties in regard to the special education programs for exceptional children, the governing bodies shall, in accordance with state law and the rules and regulations of the division of special education, establish a written agreement for the provision of services. In such agreements, one governing body of each common or high school district, agencies involved in intergovernmental agreements or the county school superintendent shall administer the program in accordance with the contract agreement between the districts. Tuition students may be included in the agreement.

2. Establish work-experience programs in accordance with rules and regulations of the division of special education. The work-experience programs shall consist of classroom instruction, evaluation, training and part-time employment. The evaluation, training and part-time employment may take place on or off the school campus, in or out of the school district, but must be under supervision of certified school personnel. Students enrolled in the work-experience program shall be at least sixteen years of age. Time in a work-experience program shall be counted as attendance at school to qualify for appropriations provided by section 15-1017. All work-experience programs must have the approval of the state division of special education.

3. Establish special education programs for gifted and emotionally handicapped children.

~~E.~~ F. A school district or county school superintendent may contract with, and make payments to, other public or private schools, institutions and agencies approved by the division of special education, within or without the district, for the education of and provision of services to exceptional children if the provisions of section 15-1013 and the conditions and standards prescribed by the division of special education have been met and if unable to provide satisfactory education and service through its own facilities and personnel in accordance with the rules and regulations prescribed by the division of special education. No school district may contract or make payments under the authority of this section or any other provision of law for the costs of placement of handicapped children in an approved private special education school, institution or agency unless such children are evaluated and placed by a public school district.

~~F.~~ G. The county school superintendent may, upon approval of the division of special education, establish special education programs in the county accommodation schools under his jurisdiction or may cooperate with other school districts by agreement to provide such services for such special programs in accordance with the rules and regulations of the division of special education. At the beginning of each school year the county school superintendent shall present an estimate of the current year's accommodation school exceptional programs tuition cost to each school district that has signed an agreement to use the services of the accommodation school. The tuition shall be the estimated per capita cost based on the number of pupils that each school district has estimated will enroll in the program and the school district shall pay the tuition quarterly in advance on July 1, October 1, January 1 and April 1. Increases in enrollment during the school year over the school district's estimate of July 1 shall cause the tuition charges to be adjusted accordingly. In the event of overpayment by the district of residence, the necessary adjustment shall be made at the close of the school year.

Sec. 8. Title 15, chapter 10, article 2, Arizona Revised Statutes, is amended by adding section 15-1015.02, to read:

15-1015.02. Reports to state board of education and department of economic security

A. EACH SCHOOL DISTRICT SHALL REPORT ANNUALLY ON OR BEFORE FEBRUARY 1 TO THE DEPARTMENT OF EDUCATION BY HANDICAPPING CATEGORY THE NUMBER AND AGES OF THOSE HANDICAPPED PUPILS AS DEFINED IN SECTION 15-1011, PARAGRAPH 3, SUBDIVISIONS (a), (e) AND (i) WHO ARE SCHEDULED TO GRADUATE FROM THE SCHOOL DISTRICT OR TO OTHERWISE TERMINATE THEIR SPECIAL EDUCATION PROGRAMS WITH THE SCHOOL DISTRICT AT OR PRIOR TO THE END OF THE SCHOOL YEAR.

B. THE DEPARTMENT SHALL COMPILE AND FORWARD SUCH INFORMATION TO THE DEPARTMENT OF ECONOMIC SECURITY BY MARCH 7 OF EACH YEAR.

Sec. 9. Title 23, chapter 3, article 1, Arizona Revised Statutes, is amended by adding section 23-503.01, to read:

23-503.01. Coordination of vocational rehabilitation services

THE DEPARTMENT SHALL COORDINATE ITS PROVISION OF VOCATIONAL REHABILITATION SERVICES TO MENTALLY RETARDED PERSONS WITH ITS PROVISION OF MENTAL RETARDATION SERVICES TO SUCH PERSONS, INCLUDING THE AREAS OF EVALUATION OF APPLICANTS FOR EITHER TYPE OF SERVICES AND THE DEVELOPMENT OF PROGRAM AND REHABILITATION PLANS FOR MENTALLY RETARDED PERSONS.

Sec. 10. Title 36, chapter 2, article 1, Arizona Revised Statutes, is amended by adding section 36-203, to read:

36-203. Mentally retarded persons assigned to state hospital; duties of department

A. THE DEPARTMENT SHALL DEVELOP AND PROVIDE, IN COORDINATION WITH THE DEPARTMENT OF ECONOMIC SECURITY, SPECIALIZED TREATMENT PROGRAMS FOR MENTALLY RETARDED PERSONS WHO HAVE BEEN ADMITTED TO THE STATE HOSPITAL. THE DEPARTMENT MAY CONTRACT WITH THE DEPARTMENT OF ECONOMIC SECURITY IN PROVIDING SUCH PROGRAMS.

B. THE DEPARTMENT SHALL, TO THE EXTENT PRACTICABLE, PROVIDE SEPARATE AREAS AT THE STATE HOSPITAL FOR PERSONS DIAGNOSED AS MENTALLY RETARDED AND SHALL, TO THE EXTENT PRACTICABLE, PROVIDE THAT TREATMENT PROGRAMS DEVELOPED PURSUANT TO SUBSECTION A ARE SEPARATE FROM TREATMENT PROGRAMS FOR OTHER PATIENTS AND FOR SEPARATE USE OF FACILITIES BY PERSONS DIAGNOSED AS MENTALLY RETARDED.

C. THE DEPARTMENT, UPON REQUEST OF A PARENT OR GUARDIAN OF A MENTALLY RETARDED MINOR, THE GUARDIAN OF A MENTALLY RETARDED ADULT OR UPON THE REQUEST OF A MENTALLY RETARDED ADULT, SHALL NOTIFY THE DEPARTMENT OF ECONOMIC SECURITY PRIOR TO THE RELEASE OF SUCH PERSON FROM THE STATE HOSPITAL AND REQUEST THAT THE DEPARTMENT OF ECONOMIC SECURITY PROVIDE PLACEMENT EVALUATION AND CASE MANAGEMENT SERVICES FOR SUCH PERSON. SUCH EVALUATION SHALL CONSIDER THE MENTALLY RETARDED PERSON'S NEEDS FOR HOUSING, DAY PROGRAMS, EMPLOYMENT TRAINING, EMPLOYMENT AND SUPPORT SERVICES.

D. THE DEPARTMENT MAY, UPON THE APPLICATION OF A PARENT OR GUARDIAN OF A MENTALLY RETARDED MINOR, THE GUARDIAN OF A MENTALLY RETARDED ADULT OR UPON THE REQUEST OF A MENTALLY RETARDED ADULT, WHEN THE MENTALLY RETARDED PERSON HAS BEEN AUTHORIZED FOR DISCHARGE FROM THE STATE HOSPITAL, PROVIDE INTERIM CARE AND CUSTODY FOR SUCH MENTALLY RETARDED PERSON PENDING THE AVAILABILITY OF MENTAL RETARDATION PROGRAMS AND SERVICES IN ACCORDANCE WITH THE PROVISIONS OF SECTION 36-554.02.

Sec. 11. Section 36-551, Arizona Revised Statutes, is amended to read:

36-551. Definitions

In this chapter, unless the context otherwise requires:

1. "ADAPTIVE BEHAVIOR" MEANS THE EFFECTIVENESS OR DEGREE TO WHICH THE INDIVIDUAL MEETS THE STANDARDS OF PERSONAL INDEPENDENCE AND SOCIAL RESPONSIBILITY EXPECTED OF THE PERSON'S AGE AND CULTURAL GROUP.

~~1.~~ 2. "Advisory council" means the mental retardation advisory council.

~~2.--"Center"-means-any-state-operated-facility-which-provides residential-care-and-training,-day-care,-sheltered-workshop,-preschool~~

~~programs,-diagnosis-and-evaluation,-or-a-combination-thereof,-for mentally-retarded-persons.~~

~~3.--"Child"-or-"person"-are-used-interchangeably-to-mean-a-mentally retarded-person-of-any-age.~~

3. "CLIENT" MEANS A PERSON RECEIVING MENTAL RETARDATION SERVICES FROM THE DEPARTMENT.

4. "COMMUNITY RESIDENTIAL ALTERNATIVES" MEANS A RESIDENTIAL LIVING ARRANGEMENT FOR MENTALLY RETARDED PERSONS OPERATED BY THE DEPARTMENT, OR BY A PROFIT OR NON-PROFIT AGENCY SUPERVISED OR FINANCIALLY SUPPORTED BY THE DEPARTMENT, IN WHICH MENTALLY RETARDED PERSONS LIVE, WITH VARYING DEGREES OF APPROPRIATE SUPERVISION.

5. "CONSENT" MEANS VOLUNTARY INFORMED CONSENT. CONSENT IS VOLUNTARY IF NOT GIVEN AS THE RESULT OF COERCION OR UNDUE INFLUENCE. CONSENT IS INFORMED IF THE PERSON GIVING THE CONSENT HAS BEEN INFORMED OF AND COMPREHENDS THE NATURE, PURPOSE, CONSEQUENCES, RISKS AND BENEFITS OF THE ALTERNATIVES TO THE PROCEDURE, AND HAS BEEN INFORMED AND COMPREHENDS THAT WITHHOLDING OR WITHDRAWAL OF CONSENT WILL NOT PREJUDICE THE FUTURE PROVISION OF CARE AND SERVICES TO THE CLIENT. IN CASES OF UNUSUAL OR HAZARDOUS TREATMENT PROCEDURES PERFORMED PURSUANT TO SECTION 36-561, SUBSECTION A, EXPERIMENTAL RESEARCH, ORGAN TRANSPLANTATION AND NON-THERAPEUTIC SURGERY, CONSENT IS INFORMED IF, IN ADDITION TO THE FOREGOING THE PERSON GIVING THE CONSENT HAS BEEN INFORMED OF AND COMPREHENDS THE METHOD TO BE USED IN THE PROPOSED PROCEDURE.

~~4.~~ 6. "Department" means the department of economic security.

~~5.~~ 7. "Director" means the director of the department of economic security.

8. "GUARDIAN" MEANS THE PERSON WHO, UNDER COURT ORDER, IS THE GUARDIAN OF THE PERSON OF ANOTHER, BUT SHALL NOT INCLUDE A GUARDIAN PURSUANT TO SECTION 36-547.

9. "HABILITATION" MEANS THE PROCESS BY WHICH AN INDIVIDUAL IS ASSISTED TO ACQUIRE AND MAINTAIN THOSE LIFE SKILLS WHICH ENABLE THE PERSON TO COPE MORE EFFECTIVELY WITH THE DEMANDS OF HIS PERSON AND ENVIRONMENT AND TO RAISE THE LEVEL OF HIS PHYSICAL, MENTAL AND SOCIAL EFFICIENCY. HABILITATION INCLUDES, BUT IS NOT LIMITED TO, PROGRAMS OF FORMAL EDUCATION AS DEFINED IN PARAGRAPH 5 OF SECTION 15-1011 AND TRAINING.

~~6.~~ 10. "Indigent" means a mentally retarded person whose estate~~,~~ OR parent~~,-or-guardian~~ is unable to bear the full cost of maintaining or providing services for such person ~~at~~ IN a mental retardation ~~center~~ RESIDENTIAL PROGRAM.

11. "INDIVIDUAL PROGRAM PLAN" MEANS A WRITTEN STATEMENT OF HABILITATION GOALS AND OBJECTIVES ESTABLISHED FOR AN INDIVIDUAL CLIENT WHICH IS DEVELOPED AFTER INITIAL PLACEMENT EVALUATION AND PERIODIC EVALUATIONS.

12. "LEAST RESTRICTIVE ALTERNATIVE" MEANS AN AVAILABLE PROGRAM OR FACILITY WHICH FOSTERS INDEPENDENT LIVING AND WHICH IS THE LEAST CONFINING FOR THE CLIENT'S CONDITION, AND SERVICE AND TREATMENT WHICH IS PROVIDED IN THE LEAST INTRUSIVE MANNER REASONABLY AND HUMANELY APPROPRIATE TO THE INDIVIDUAL'S NEEDS.

13. "MENTAL RETARDATION" OR "MENTALLY RETARDED" OR "RETARDED" MEANS A CONDITION INVOLVING SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING EXISTING CONCURRENTLY WITH DEFICITS IN ADAPTIVE BEHAVIOR MANIFESTED DURING THE DEVELOPMENTAL PERIOD. FOR PURPOSES OF THIS PARAGRAPH THE "DEVELOPMENTAL PERIOD" MEANS A PERSON'S LIFE UP TO AGE EIGHTEEN.

14. "MENTAL RETARDATION PROGRAMS AND SERVICES" MEANS THOSE PROGRAMS AND SERVICES PROVIDED DIRECTLY BY THE DEPARTMENT TO A MENTALLY RETARDED PERSON OR INDIRECTLY THROUGH FUNDING PROVIDED BY THE DEPARTMENT, INCLUDING CHILD SERVICES, ADULT SERVICES, SUPPORT SERVICES AND RESIDENTIAL SERVICES, BUT SHALL NOT INCLUDE THOSE PROGRAMS OR SERVICES WHICH HAVE BEEN SPECIFICALLY DELEGATED BY LAW TO OTHER STATE AGENCIES OR TO SCHOOL DISTRICTS.

15. "MINOR" MEANS A PERSON UNDER EIGHTEEN YEARS OF AGE.

16. "PHYSICIAN" MEANS A PERSON LICENSED TO PRACTICE PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

17. "PLACEMENT EVALUATION" MEANS AN INTERVIEW AND EVALUATION OF A MENTALLY RETARDED PERSON AND A REVIEW OF THE PERSON'S PRIOR MEDICAL AND PROGRAM HISTORIES TO DETERMINE THE APPROPRIATE MENTAL RETARDATION PROGRAMS AND SERVICES FOR SUCH PERSON AND MAKE RECOMMENDATIONS FOR SPECIFIC PROGRAM PLACEMENTS FOR SUCH PERSON.

18. "PSYCHOLOGIST" MEANS A PERSON CERTIFIED PURSUANT TO TITLE 32, CHAPTER 19.1.

19. "RESPONSIBLE PERSON" MEANS THE PARENT OR GUARDIAN OF A MENTALLY RETARDED MINOR, THE GUARDIAN OF A MENTALLY RETARDED ADULT, OR A MENTALLY RETARDED ADULT WHO IS A CLIENT OR AN APPLICANT FOR WHOM NO GUARDIAN HAS BEEN APPOINTED.

20. "SUBAVERAGE GENERAL INTELLECTUAL FUNCTIONING" MEANS MEASURED INTELLIGENCE ON STANDARDIZED PSYCHOMETRIC INSTRUMENTS OF TWO OR MORE STANDARD DEVIATIONS BELOW THE MEAN FOR THE TESTS USED.

Sec. 12. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding section 36-551.01, to read:

36-551.01. Recognition and protection of the individual dignity and worth of mentally retarded persons

A. NO MENTALLY RETARDED PERSON IN THIS STATE SHALL BE DENIED AS THE RESULT OF SUCH MENTAL RETARDATION THE RIGHTS, BENEFITS, AND PRIVILEGES GUARANTEED BY THE CONSTITUTION AND LAWS OF THE UNITED STATES AND THE CONSTITUTION AND LAWS OF THE STATE OF ARIZONA. THE RIGHTS OF MENTALLY RETARDED PERSONS WHICH ARE SPECIFICALLY ENUMERATED IN THIS CHAPTER ARE IN ADDITION TO ALL OTHER RIGHTS ENJOYED BY SUCH PERSONS. SUCH LISTING OF RIGHTS IS NOT EXCLUSIVE OR INTENDED TO LIMIT IN ANY WAY RIGHTS WHICH ARE GUARANTEED TO THE MENTALLY RETARDED UNDER STATE AND FEDERAL LAWS.

B. EVERY MENTALLY RETARDED PERSON SHALL HAVE THE RIGHT TO PROTECTION FROM EXPLOITATION AND ABUSE ON THE BASIS OF MENTAL RETARDATION.

C. EVERY MENTALLY RETARDED PERSON WHO IS PROVIDED RESIDENTIAL CARE BY THE STATE SHALL HAVE THE RIGHT TO LIVE IN THE LEAST RESTRICTIVE ALTERNATIVE, AS DETERMINED AFTER AN INITIAL PLACEMENT EVALUATION HAS BEEN CONDUCTED FOR SUCH PERSON.

D. EVERY SCHOOL-AGE MENTALLY RETARDED PERSON SHALL HAVE THE RIGHT TO RECEIVE PUBLICLY-SUPPORTED EDUCATIONAL SERVICES IN ACCORDANCE WITH THE APPLICABLE SPECIFIC EDUCATION LAWS OF THE STATE.

E. NO EMPLOYER, EMPLOYMENT AGENCY OR LABOR ORGANIZATION SHALL DENY A PERSON EQUAL EMPLOYMENT OPPORTUNITY BECAUSE OF MENTAL RETARDATION EXCEPT WHEN:

1. THE DENIAL IS BASED ON A BONA FIDE OCCUPATIONAL QUALIFICATION REASONABLY NECESSARY TO THE NORMAL OPERATION OF THE PARTICULAR BUSINESS OR ENTERPRISE, AND

2. THE PERSON'S MENTAL RETARDATION SIGNIFICANTLY IMPAIRS HIS ABILITY TO MEET THE QUALIFICATIONS FOR THE POSITION IN QUESTION.

F. NO OWNER, LESSEE, SUBLESSEE, ASSIGNEE, OR MANAGING AGENT OF, OR OTHER PERSON HAVING THE RIGHT TO SELL, RENT OR LEASE ANY REAL PROPERTY OR AGENCY OR EMPLOYEE OF SUCH PERSON MAY REFUSE TO SELL, RENT OR LEASE TO ANY PERSON OR GROUP OF PERSONS SOLELY ON THE BASIS OF MENTAL RETARDATION.

G. ANY MENTALLY RETARDED PERSON REQUESTING TO BE PROVIDED MENTAL RETARDATION PROGRAMS OR SERVICES SHALL HAVE THE RIGHT, PRIOR TO RECEIVING SUCH PROGRAMS OR SERVICES, TO RECEIVE A PLACEMENT EVALUATION TO DETERMINE THE NEED FOR MENTAL RETARDATION SERVICES AND TO DETERMINE THE APPROPRIATE SERVICES FOR SUCH PERSON.

H. MENTALLY RETARDED PERSONS SHALL HAVE THE RIGHT TO PRESUMPTION OF LEGAL COMPETENCY IN GUARDIANSHIP PROCEEDINGS.

I. MENTALLY RETARDED PERSONS SHALL HAVE THE RIGHT TO FAIR COMPENSATION FOR LABOR.

J. EACH CLIENT WHO HAS BEEN ACCEPTED TO RECEIVE MENTAL RETARDATION SERVICES SHALL HAVE THE RIGHT TO RECEIVE A WRITTEN INDIVIDUAL PROGRAM PLAN. EACH PLAN SHALL BE DEVELOPED BY APPROPRIATE DEPARTMENT PERSONNEL WITH THE PARTICIPATION OF THE CLIENT, HIS OR HER PARENTS, AND HIS OR HER GUARDIAN, IF ANY, AND SHALL BE BASED ON THE RELEVANT RESULTS OF THE PLACEMENT EVALUATION.

K. EVERY CLIENT SHALL HAVE THE RIGHT TO PERIODIC REVIEW OF THE INDIVIDUAL PROGRAM PLAN TO MEASURE PROGRESS, TO MODIFY OBJECTIVES AND PROGRAMS IF NECESSARY, AND TO PROVIDE GUIDANCE AND REMEDIATION TECHNIQUES.

L. EACH CLIENT, AND EACH PARENT OR GUARDIAN OF A MINOR CLIENT OR THE GUARDIAN OF AN ADULT CLIENT SHALL HAVE THE RIGHT TO PARTICIPATE IN THE CLIENT'S INITIAL PLACEMENT EVALUATION AND PERIODIC EVALUATIONS AND TO BE INFORMED IN WRITING OF THE CLIENT'S PROGRESS AT REASONABLE INTERVALS. WHENEVER POSSIBLE, THE RESPONSIBLE PERSON SHALL BE GIVEN THE OPPORTUNITY TO DECIDE AMONG SEVERAL APPROPRIATE ALTERNATIVE SERVICES AVAILABLE TO THE CLIENT FROM THE SERVICE PROVIDER.

M. THE RESPONSIBLE PERSON SHALL HAVE THE RIGHT TO WITHDRAW THE CLIENT FROM MENTAL RETARDATION PROGRAMS AND SERVICES, EXCEPT IN THE EVENT THAT THE CLIENT WAS ASSIGNED TO THE DEPARTMENT BY THE JUVENILE COURT.

N. CLIENTS SHALL HAVE THE RIGHT TO BE FREE FROM MISTREATMENT, NEGLECT AND ABUSE BY SERVICE PROVIDERS.

O. EACH CLIENT SHALL HAVE THE RIGHT TO BE FREE FROM UNNECESSARY AND EXCESSIVE MEDICATION. MEDICATION SHALL NOT BE USED AS PUNISHMENT, FOR THE CONVENIENCE OF THE STAFF, AS A SUBSTITUTE FOR AN INDIVIDUAL

PROGRAM PLAN, OR IN QUANTITIES THAT INTERFERE WITH THE CLIENT'S INDIVIDUAL PROGRAM PLAN. PRESCRIPTION-ONLY MEDICATION FOR EACH CLIENT SHALL BE AUTHORIZED ONLY BY THE PRESCRIPTION OF A PHYSICIAN AND THE ADMINISTRATION OF SUCH MEDICATION SHALL BE DIRECTED BY A PHYSICIAN.

P. ON ADMISSION FOR MENTAL RETARDATION SERVICES, EACH CLIENT, HIS OR HER PARENTS AND HIS OR HER GUARDIAN, IF ANY, SHALL BE GIVEN WRITTEN NOTICE, IF POSSIBLE, AND ORAL NOTICE IN THEIR PRIMARY LANGUAGE, IN A MANNER WHICH CAN BE EASILY UNDERSTOOD, OF THE RIGHTS INCLUDED IN THIS CHAPTER, INCLUDING THE RIGHT TO ADMINISTRATIVE REVIEWS. IF WRITTEN OR ORAL LANGUAGE IS NOT THE PRIMARY MODE OF COMMUNICATION OF THE CLIENT, HIS OR HER PARENT OR HIS OR HER GUARDIAN, THEN NOTICE SHALL BE GIVEN TO SUCH PERSON IN THE PRIMARY MODE OF COMMUNICATION, IF POSSIBLE. HOWEVER, IF A CLIENT IS MANIFESTLY UNABLE TO COMPREHEND THESE RIGHTS, NOTICE TO THE PARENT OR GUARDIAN OF A MINOR CLIENT OR TO THE GUARDIAN OF AN ADULT CLIENT SHALL BE SUFFICIENT.

Q. MENTALLY RETARDED PERSONS WHO ARE RESIDENTS IN RESIDENTIAL PROGRAMS OPERATED OR SUPPORTED BY THE DEPARTMENT SHALL HAVE THE RIGHT TO A HUMANE AND CLEAN PHYSICAL ENVIRONMENT, THE RIGHT TO COMMUNICATION AND VISITS AND THE RIGHT TO PERSONAL PROPERTY.

R. ANY CLIENT OR THE PARENT OR GUARDIAN OF A MINOR CLIENT OR THE GUARDIAN OF AN ADULT CLIENT WHO BELIEVES THAT HIS RIGHTS, AS ESTABLISHED BY THIS CHAPTER OR BY THE CONSTITUTION OF THE UNITED STATES OR THE CONSTITUTION OF ARIZONA, HAVE BEEN VIOLATED SHALL HAVE A RIGHT TO PETITION THE SUPERIOR COURT FOR REDRESS.

Sec. 13. Section 36-552, Arizona Revised Statutes, is amended to read:

36-552. Mental retardation function

A. The department shall function as the mental retardation authority for the state of Arizona, provided that nothing in this chapter shall be deemed to conflict with or alter the provisions in chapter 10 of this title.

B. No provisions of this chapter shall be construed to give the department control of lawful activities of other governmental agencies or of activities of the universities or colleges of this state in the field of mental retardation, unless by specific contract or agreement therefor.

C. SUBJECT TO ANNUAL LEGISLATIVE APPROPRIATION AND OTHER AVAILABLE FUNDING, THE DEPARTMENT SHALL PROVIDE A WIDE VARIETY OF MENTAL RETARDATION PROGRAMS AND SERVICES THROUGHOUT THE STATE IN RESPONSE TO THE WIDE RANGE OF MENTAL RETARDATION CONDITIONS, THE CAPABILITIES OF THE MENTALLY RETARDED PERSONS AND THE PRESENCE OF OTHER HANDICAPPING CONDITIONS FOR MENTALLY RETARDED PERSONS.

D. THE DEPARTMENT MAY CONTRACT WITH OTHER STATE AGENCIES AND WITH PRIVATE AGENCIES TO PROVIDE THE MENTAL RETARDATION PROGRAM OR SERVICE.

Sec. 14. Section 36-553, Arizona Revised Statutes, is amended to read:

36-553. Mental retardation advisory council;
members; compensation; duties

A. There shall be a mental retardation advisory council composed of ~~at-least-eight~~ THIRTEEN members who shall be persons interested in mental retardation WHO SHALL NO[illegible]MPLOYEES OF THE DEPARTMENT and WHO SHALL be appointed as follows:

1. ~~Three~~ TWELVE members appointed by the director of the department of economic security TO REPRESENT THE GEOGRAPHICAL REGIONS OF THE STATE ESTABLISHED FOR PLANNING PURPOSES. SUCH PERSONS SHALL BE APPOINTED FROM:

(a) PARENTS OR OTHER RELATIVES OR GUARDIANS OF MENTALLY RETARDED PERSONS.

(b) MEMBERS OR OFFICERS OF MENTAL RETARDATION CLIENT ADVOCACY GROUPS.

(c) INDIVIDUAL HEALTH CARE PROVIDERS LICENSED PURSUANT TO TITLE 32.

(d) MEMBERS OF PROFESSIONS RELATED TO MENTAL RETARDATION INCLUDING PSYCHIATRY, PSYCHOLOGY, LAW AND EDUCATION. AT LEAST THREE OF SUCH MEMBERS SHALL BE APPOINTED TO THE ADVISORY COUNCIL. THE MAJORITY OF THE MEMBERS OF THE ADVISORY COUNCIL SHALL BE PARENTS OR OTHER RELATIVES OF MENTALLY RETARDED PERSONS.

~~One-such-member,-who-shall-serve-as-chairman,-shall-be-the-employee-of-the department-of-economic-security-chiefly-responsible-for-the-mental-retardation-programs-of-the-department.~~

~~2.--Two-members-appointed-by-the-director-of-the-department-of health-services.~~

~~3.--Two-members-appointed-by-the-superintendent-of-public-instruction-of-the-department-of-education.~~

~~4.~~ 2. One member appointed by the governor TO SERVE AS CHAIRMAN.

~~5.--The-director-of-the-department-of-economic-security-may-appoint, with-the-advice-of-the-mental-retardation-advisory-council,-such-additional members-as-he-may-deem-necessary.~~

~~6.~~ B. Members of the mental retardation advisory council shall serve at the pleasure of the appointing authority and shall receive PER DIEM compensation determined pursuant to ~~section-38-611~~ TITLE 38, CHAPTER 4, ARTICLE 2.

~~8.~~ C. The mental retardation advisory council shall:

1. ~~Insure-that~~ REVIEW AND MAKE RECOMMENDATIONS FOR IMPROVING THE coordination and integration of services ~~are~~ provided by ~~these~~ state agencies having mental retardation programs.

2. Report to the legislature and the governor once each year on the effectiveness of the state's mental retardation programs in providing services to the ~~mental-retardate-and-his-family~~ MENTALLY RETARDED.

~~3.--Perform-such-other-duties-and-functions-as-may-be-requested by-the-director-of-the-department-of-economic-security.~~

3. MEET NOT LESS THAN QUARTERLY. A MAJORITY OF MEMBERS SHALL CONSTITUTE A QUORUM.

4. REVIEW AND MAKE RECOMMENDATIONS REGARDING THE HEALTH, SAFETY, WELFARE AND LEGAL AND HUMAN RIGHTS OF MENTALLY RETARDED PERSONS BEING SERVED BY THE DEPARTMENT.

D. THE DEPARTMENT SHALL MAKE MEETING SPACE AVAILABLE AT CONVENIENT LOCATIONS AND AT REASONABLE TIMES FOR THE USE OF THE COUNCIL AND SHALL PROVIDE SECRETARIAL AND OTHER STAFF SUPPORT TO THE COUNCIL.

Sec. 15. Section 36-554, Arizona Revised Statutes, is amended to read:

36-554. Powers and duties of director

A. The director shall:

1. Be responsible for DEVELOPING, AND ANNUALLY REVISING A STATEWIDE PLAN ~~planning~~ and ~~developing~~ INITIATING statewide programs and service to the mentally retarded IN LOCATIONS WHERE SUCH PROGRAMS AND SERVICES ARE NECESSARY, which ~~may~~ SHALL include:

~~(a)--Programs-and-services-offered-in-cooperation-with-private and-public-resources-that-can-best-meet-the-needs-of-the-mentally retarded-and-which-are-located-in-the-community-and-in-proximity-to the-persons-being-served.~~

~~(b)--Residential-and-day-care-programs-and-services-located-in centers-which-offer-a-more-complete-spectrum-of-services-to-the-mentally retarded.~~

(a) CHILD SERVICES, WHICH MAY INCLUDE BUT NOT BE LIMITED TO INFANT STIMULATION, DEVELOPMENTAL TRAINING FOR PRE-SCHOOL CHILDREN AND SPECIAL EDUCATION AT THE DEPARTMENT'S INSTITUTIONAL FACILITIES FOR SCHOOL AGED, MENTALLY RETARDED CHILDREN RESIDING AT THE DEPARTMENT'S INSTITUTIONAL FACILITIES WHO DO NOT ATTEND PUBLIC SCHOOL.

(b) ADULT SERVICES, IN COORDINATION WITH THE VOCATIONAL REHABILITATION SERVICES OF THE DEPARTMENT, WHICH MAY INCLUDE BUT NOT BE LIMITED TO JOB TRAINING AND TRAINING AND ADJUSTMENT SERVICES, JOB DEVELOPMENT AND PLACEMENT, SHELTERED EMPLOYMENT AND OTHER NONVOCATIONAL DAY ACTIVITY SERVICES FOR ADULTS.

(c) RESIDENTIAL SERVICES, INCLUDING BUT NOT LIMITED TO VARIOUS COMMUNITY RESIDENTIAL ALTERNATIVES, SPECIAL FOSTER CARE HOMES AND STATE HOUSING FACILITIES TO PROVIDE VARYING LEVELS OF SUPERVISION AT SUCH HOMES IN ACCORDANCE WITH THE MENTAL RETARDATION LEVELS OF THE PERSONS PLACED AT SUCH HOMES, INCLUDING RESPITE CARE. THE DEPARTMENT SHALL, IN ACCORDANCE WITH THE EXPRESSED NEED FOR SUCH FACILITIES AND IN ADDITION TO OTHER TYPES OF COMMUNITY RESIDENTIAL ALTERNATIVES, CONTRACT WITH PRIVATE, PROFIT OR NON-PROFIT AGENCIES TO PROVIDE APPROPRIATE RESIDENTIAL SERVICES FOR MENTALLY RETARDED PERSONS AT VARIOUS MODERATE-SIZED FACILITIES WHICH PROVIDE FOR REGULAR ASSISTANCE AND SUPERVISION OF SUCH PERSONS AND WHICH ON OR NEAR THE SITES OF SUCH FACILITIES PROVIDE VARYING SCOPES OF MENTAL RETARDATION PROGRAMS AND SERVICES.

(d) RESOURCE SERVICES, WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, COMPREHENSIVE EVALUATION SERVICES, INFORMATION AND REFERRAL SERVICES AND OUTPATIENT REHABILITATION AND SOCIAL DEVELOPMENT SERVICES.

THE DEPARTMENT IN PROVIDING MENTAL RETARDATION PROGRAMS AND SERVICES SHALL WHENEVER PRACTICABLE UTILIZE QUALIFIED PRIVATE CONTRACTORS. IN SELECTING PRIVATE CONTRACTORS, THE DEPARTMENT SHALL UTILIZE THOSE CONTRACTORS WHICH CAN CLEARLY DEMONSTRATE AN ABILITY TO PERFORM SUCH CONTRACT IN ACCORDANCE WITH STANDARDS AND SPECIFICATIONS ADOPTED BY THE DEPARTMENT.

2. Establish standards, provide technical assistance, and ~~exercise the-requisite-supervision-of~~ SUPERVISE all ~~state-operated~~ mental retardation ~~centers,-regional-offices,-diagnostic-facilities,-day-care-centers,-rehab~~
~~tation-centers,-sheltered-workshops,-boarding-homes-and-other-state-operat~~

~~facilities-for-the-mentally-retarded~~ PROGRAMS AND SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT.

3. Coordinate the planning and implementation of mental retardation programs and activities, institutional and community, of all state agencies, provided this shall not be construed as depriving other state agencies of jurisdiction over, or the right to plan for and control, and operate programs that pertain to mental retardation programs but which fall within the primary jurisdiction of such other state agencies.

4. Do all other things reasonably necessary and proper to carry out ~~its~~ HIS OR HER duties and the provisions of this chapter.

B. PROGRAMS AND SERVICES OFFERED PURSUANT TO PARAGRAPH 1 OF SUBSECTION A OF THIS SECTION SHALL BE PROVIDED IN COOPERATION WITH PUBLIC AND PRIVATE RESOURCES THAT CAN BEST MEET THE NEEDS OF MENTALLY RETARDED PERSONS AND WHICH ARE LOCATED IN THE COMMUNITY AND IN PROXIMITY TO THE PERSONS BEING SERVED.

~~B.~~ C. The director may:

1. ~~After-consultation-with-the-superintendent-of-a-center~~ Establish nonresidential outpatient programs ~~at-a-center~~ for ~~diagnosis~~ PLACEMENT EVALUATION, care, treatment~~,-~~ and training of mentally retarded persons residing in the community who are not eligible for public school programs, and who do not have access to other state supported programs providing equivalent services.

2. Develop cooperative programs with other state departments and agencies, political subdivisions of the state, and private agencies concerned with and providing services for the mentally retarded.

3. Contract for purchase of services with other state and local governmental or private agencies. Such agencies are authorized to accept and expend funds received pursuant to such contracts.

4. Stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the prevention of mental retardation and improved methods of care and training for the mentally retarded.

5. Apply for, accept, receive, hold in trust or use in accordance with the terms of the grant or agreement any public or private funds or properties, real or personal, granted or transferred to it for any purpose authorized by this chapter.

6. Make and amend rules and regulations from time to time as deemed necessary for the proper administration of ~~the-centers,~~ FACILITIES, PROGRAMS AND SERVICES for ~~voluntary-admission-for-residential-and-outpatient~~ THE treatment of mentally retarded persons, FOR THE ADMISSION OF MENTALLY RETARDED PERSONS to SUCH ~~the-centers~~ FACILITIES, PROGRAMS AND SERVICES and to carry out the purposes of this chapter.

Sec. 16. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding sections 36-554.01 and 36-554.02, to read:

36-554.01. Coordination of programs by department with special education programs

A. THE DEPARTMENT MAY CONDUCT JOINTLY, DIRECTLY OR INDIRECTLY, WITH A SCHOOL DISTRICT THE PLACEMENT EVALUATION OF A MENTALLY RETARDED PERSON

WHO HAS APPLIED FOR OR IS RECEIVING MENTAL RETARDATION PROGRAMS OR SERVICES FROM THE DEPARTMENT AND WHO IS ALSO ENROLLED IN A SPECIAL EDUCATION PROGRAM WITHIN THE SCHOOL DISTRICT, OR MAY CONTRACT WITH SUCH SCHOOL DISTRICT TO PROVIDE THE EVALUATION FOR THE SCHOOL DISTRICT OR TO HAVE THE SCHOOL DISTRICT PROVIDE THE PLACEMENT EVALUATION FOR THE DEPARTMENT.

B. THE DEPARTMENT SHALL COORDINATE ITS DEVELOPMENT OF AN INDIVIDUAL PROGRAM PLAN FOR A MENTALLY RETARDED PERSON WHO HAS APPLIED FOR OR WHO IS RECEIVING MENTAL RETARDATION PROGRAMS OR SERVICES PROVIDED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT WITH THE SCHOOL DISTRICT IN WHICH THE MENTALLY RETARDED PERSON IS ENROLLED WITH THE SCHOOL DISTRICT'S DEVELOPMENT OF AN INDIVIDUAL EDUCATION PROGRAM PLAN FOR SUCH PERSON.

C. WHEN A MENTALLY RETARDED CHILD HAS RECEIVED MENTAL RETARDATION PROGRAMS OR SERVICES PROVIDED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT, UPON REQUEST OF THE RESPONSIBLE PERSON OR THE SCHOOL DISTRICT IN WHICH THE CHILD IS ENROLLED, THE DEPARTMENT SHALL PROVIDE FOLLOW-UP PLACEMENT EVALUATION AND CASE MANAGEMENT SERVICES FOR THE MENTALLY RETARDED CHILD FOR A PERIOD OF SIX MONTHS AFTER THE CHILD HAS BECOME ENROLLED IN THE SCHOOL DISTRICT.

D. DURING THE ONE-YEAR PERIOD PRIOR TO THE GRADUATION OR OTHER TERMINATION OF SCHOOL ATTENDANCE BY A MENTALLY RETARDED PERSON, THE DEPARTMENT SHALL, UPON THE REQUEST OF THE RESPONSIBLE PERSON PROVIDE PLACEMENT EVALUATION AND CASE MANAGEMENT SERVICES FOR SUCH PERSON. SUCH EVALUATION SHALL CONSIDER THE PERSONS' NEEDS FOR HOUSING, EMPLOYMENT TRAINING, EMPLOYMENT AND SUPPORT SERVICES.

E. THE DEPARTMENT SHALL REPORT ANNUALLY ON OR BEFORE FEBRUARY 1 TO THE STATE DEPARTMENT OF EDUCATION AND TO SCHOOL DISTRICTS IN WHICH MENTALLY RETARDED CHILDREN RESIDE, THE NUMBER, LEVELS OF MENTAL RETARDATION AND THE PRESENCE OR ABSENCE OF OTHER HANDICAPPING CONDITIONS OF SUCH CHILDREN, CHILDREN RECEIVING MENTAL RETARDATION PROGRAMS AND SERVICES FROM THE DEPARTMENT, OR OTHERWISE KNOWN TO THE DEPARTMENT, AND THE NUMBER OF MENTALLY RETARDED CHILDREN WHO WILL REACH AGE FIVE OR WILL OTHERWISE BE ENTERING THE SCHOOL DISTRICT WITHIN THE FOLLOWING FISCAL YEAR.

F. THE DEPARTMENT SHALL COORDINATE THE RESIDENTIAL PLACEMENT OF ALL SCHOOL-AGE MENTALLY RETARDED PERSONS IN RESIDENTIAL HOUSING FACILITIES OPERATED OR SUPPORTED BY THE DEPARTMENT WITH THE SCHOOL DISTRICTS IN WHICH SUCH RESIDENTIAL FACILITIES WILL BE LOCATED AND WITH THE DEPARTMENT OF EDUCATION IN A MANNER WHICH WILL MAKE BEST USE OF EXISTING PROGRAMS AND FACILITIES AND OPERATIONAL CAPABILITIES AND WHICH WILL NOT CAUSE SERIOUS OVERCROWDING OF SCHOOL FACILITIES OR PROGRAMS.

36-554.02. Coordination with department of health services; duties of department

THE DEPARTMENT SHALL COORDINATE WITH THE DEPARTMENT OF HEALTH SERVICES IN:

1. THE DEVELOPMENT OF SPECIALIZED PROGRAMS FOR MENTALLY RETARDED PERSONS AT THE STATE HOSPITAL.

2. PLANNING AND PROVIDING RESIDENTIAL CARE SERVICES AND RELATED CHILD, ADULT AND RESOURCE SERVICES FOR MENTALLY RETARDED PERSONS UPON THEIR DISCHARGE FROM THE STATE HOSPITAL, IN ACCORDANCE WITH SECTION 36-560.

THE DEPARTMENT OF HEALTH SERVICES SHALL PROVIDE NOTICE FIFTEEN DAYS PRIOR TO DISCHARGE.

Sec. 17. Repeal

Section 36-556, Arizona Revised Statutes, is repealed.

Sec. 18. Section 36-557, Arizona Revised Statutes, is amended to read:

36-557. Purchase of community mental retardation services; application; contracts; limitation

A. The department may use state and federal funds appropriated or otherwise available to it for this purpose to assist in the establishment and maintenance of local mental retardation services by public or private nonprofit OR PROFIT agencies. Such funds may be expended in professional fees for service or in contracts for advancement or reimbursement or in other appropriate manner, and may be used for any purpose necessary to the provision of local mental retardation services. They may not be used for departmental salaries, care of ~~retardates~~ MENTALLY RETARDED PERSONS by the department, or any other purpose within the department itself, but they may be used for consultation to the department in the interest of local programs.

B. A local public or private nonprofit OR PROFIT agency providing or intending to provide community mental retardation services and desiring to contract with the department for the furnishing of such services shall submit a program plan and budget to the department on the forms and in the manner required by the department. If the program meets departmental standards and is consistent with the state plan of the department, the department may contract with such agency for such services as are required and upon such terms and conditions as the department shall require. Such contracts shall provide that the provider of services shall be subject to a continuing program evaluation by the department through progress reports, expenditure reports, program audits or other appropriate evaluation techniques to assure that the provider of service is in continued compliance with the terms of the contract and the department's community mental retardation service standards and requirements.

C. Contracts between the department and a school district or districts shall be subject to approval by the department of education.

D. The provisions of this article shall not be construed to place upon the department or the state ~~any-liability-for-the-well-being-and care-of-retarded-persons-in-local-programs,-or~~ responsibility for funding such programs beyond the limits of legislative appropriation therefor.

E. CONTRACTS TO PROVIDE COMMUNITY MENTAL RETARDATION SERVICES SHALL REQUIRE:

1. THAT THE CONTRACTOR IS OBLIGATED TO OPERATE A PROGRAM, SERVICE OR FACILITY IN STRICT ACCORDANCE WITH THE STANDARDS ADOPTED FOR SUCH PROGRAM OR SERVICE BY THE DEPARTMENT.

2. THAT WHEN STATE FUNDING IS PROVIDED FOR A PARTICULAR PROGRAM THE CONTRACTOR MUST TO THE EXTENT OF POSITIONS AVAILABLE WHICH ARE BEING PURCHASED BY THE DEPARTMENT PROVIDE SERVICES TO A MENTALLY RETARDED CLIENT WHO HAS BEEN EVALUATED AND PLACED BY THE DEPARTMENT.

3. THAT BEGINNING ON JULY 1, 1980 ALL CONTRACTORS MUST CARRY LIABILITY INSURANCE IN AMOUNTS APPROVED BY THE RISK MANAGEMENT SECTION OF THE DEPARTMENT OF ADMINISTRATION AND FILE PROOF OF SUCH INSURANCE WITH THE RISK MANAGEMENT SECTION. THE DIRECTOR MAY WAIVE SUCH REQUIREMENT ON A CASE BY CASE BASIS UPON A FINDING THAT INSURANCE FOR SUCH PROGRAM OR SERVICE IS NOT PRACTICABLY AVAILABLE AT AFFORDABLE RATES AND THAT IT IS NECESSARY THAT THE PROGRAM OR SERVICE BE PROVIDED BY THE CONTRACTOR.

4. THAT ALL CLIENTS ENROLLED IN PROGRAMS SHALL HAVE ALL THE SAME SPECIFIED RIGHTS AS THEY WOULD HAVE IF ENROLLED IN A PROGRAM OPERATED DIRECTLY BY THE STATE.

5. THAT, EXCEPT FOR EMERGENCY PLACEMENT PURSUANT TO SUBSECTION N OF SECTION 36-560, NO PAYMENT WILL BE MADE BASED ON PROGRAM SERVICES PROVIDED TO A CLIENT FOR WHICH NO PLACEMENT EVALUATION HAS BEEN MADE AND NO INDIVIDUAL PROGRAM HAS BEEN PREPARED AND WHEN, UPON SUCH PLACEMENT EVALUATION, NO RECOMMENDATION HAS BEEN MADE TO ENROLL THE CLIENT IN THE PARTICULAR PROGRAM SERVICE.

F. CONTRACTS FOR THE PURCHASE OF RESIDENTIAL CARE SERVICES SHALL, IN ADDITION TO OTHER GENERAL REQUIREMENTS APPLICABLE TO PURCHASE OF CARE CONTRACTORS:

1. PROVIDE FOR MANDATORY PERIODIC INSPECTION BY THE DEPARTMENT AT INTERVALS OF NOT MORE THAN SIX MONTHS.

2. SPECIFY THE HEALTH AND SAFETY AND SANITATION CODES AND OTHER CODES OR STANDARDS APPLICABLE TO THE FACILITY OR TO THE OPERATION OF THE FACILITY BY THE CONTRACTOR.

3. PROVIDE FOR MANDATORY PERIODIC REPORTS TO BE FILED BY THE CONTRACTOR WITH THE DEPARTMENT WITH RESPECT TO THE OPERATION OF THE FACILITY.

4. PROVIDE THAT THE FACILITY AND THE BOOKS AND RECORDS OF THE FACILITY AND OF THE PROVIDER ARE SUBJECT TO INSPECTION AT ANY TIME BY EMPLOYEES OF THE DEPARTMENT OR DESIGNEES OF THE DEPARTMENT.

5. PROVIDE THAT PARENTS AND GUARDIANS OF MENTALLY RETARDED PERSONS RESIDING AT THE FACILITY, MEMBERS OF THE MENTAL RETARDATION ADVISORY COUNCIL, AND MEMBERS OF OTHER RECOGNIZED AND ONGOING ADVOCACY GROUPS FOR MENTALLY RETARDED PERSONS MAY INSPECT SUCH FACILITY AT REASONABLE TIMES.

Sec. 19. Section 36-558, Arizona Revised Statutes, is amended to read:

36-558. Establishment and maintenance of programs, services and facilities

A. In addition to the ~~centers~~ DEPARTMENT FACILITIES at Randolph, ~~and~~ Tucson AND PHOENIX, the director may establish and maintain mental retardation ~~centers~~ PROGRAMS, SERVICES OR FACILITIES at other locations throughout the state, subject to the availability of funds for such purpose and the approval of the legislature.

B. The director shall be responsible for the ~~planning-and~~ operation of each ~~center~~ MENTAL RETARDATION PROGRAM, SERVICE OR FACILITY, ~~and~~ shall coordinate THESE services and permit ~~cooperation-and~~ THE transfer of residents between the various ~~centers~~ PROGRAMS AND FACILITIES.

C. ~~Each-center~~ THE DEPARTMENT may provide, BUT NOT BE LIMITED TO, the following PROGRAMS AND services in addition to other services prescribed by the director:

~~1.--Consultation-and-guidance-for-retardates-and-their-families.~~

~~2.--Residential-care-for-mentally-retarded-of-all-levels-of retardation.~~

~~3.--Diagnostic-and-evaluative-services-when-such-services-are nonexistent-in-the-area-served-by-the-center.~~

~~4.--Preschool-programs-for-young-retardates-living-at-the-center or-at-home.~~

~~5.--Day-care-services-for-school-age-retardates-not-eligible-for public-schools-who-are-living-at-the-center-or-at-home.~~

~~6.--Day-care-services-for-adult-retardates-living-at-the-center-or at-home.~~

~~7.--Overnight-and-temporary-residential-privileges-for-retardates not-admitted-for-regular-residential-care-at-the-center.~~

~~8.--Postschool-vocational-training-and-vocational-rehabilitation services-for-retardates-living-at-the-center-or-at-home.--Such-services may-include:~~

~~(a)--Vocational-trainee-programs-in-service-occupations-on-the grounds-of-the-center.~~

~~(b)--Extended-vocational-training-programs-for-retardates.~~

~~(c)--Sheltered-workshop-programs-for-those-retardates-requiring continued-supervised-and-sheltered-occupational-opportunity.~~

~~9.--Consultation-services-to-community-operated-programs-for mentally-retarded.~~

1. CHILD SERVICES, WHICH MAY INCLUDE:

(a) INFANT STIMULATION.

(b) DEVELOPMENTAL DAY TRAINING AND RELATED PRE-SCHOOL PROGRAMS.

(c) SPECIAL EDUCATION AT DEPARTMENT FACILITIES.

2. ADULT SERVICES, WHICH MAY INCLUDE:

(a) JOB TRAINING FOR SPECIFIC JOBS.

(b) TRAINING AND PERSONAL ADJUSTMENT TOOLS SUCH AS THE TEACHING OF WORK SKILLS.

(c) JOB DEVELOPMENT AND PLACEMENT.

(d) THE PROVISION OF SHELTERED EMPLOYMENT OPPORTUNITIES.

(e) ADULT DAY ACTIVITY SERVICES.

3. RESIDENTIAL SERVICES, WHICH MAY INCLUDE:

(a) COMMUNITY RESIDENTIAL ALTERNATIVES UNDER VARYING DEGREES OF SUPERVISION OR A SEMI-INDEPENDENT LIVING ARRANGEMENT.

(b) RESPITE CARE.

4. RESOURCE SERVICES, WHICH MAY INCLUDE:

(a) DIAGNOSIS AND EVALUATION.

(b) THERAPY SERVICES, INCLUDING PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY AND BEHAVIORAL THERAPY.

(c) HEALTH-RELATED SERVICES, INCLUDING DENTAL SERVICES.

(d) SOCIAL DEVELOPMENT AND ADJUSTMENT SERVICES, INCLUDING RECREATION PROGRAMS.

(e) TRANSPORTATION.

(f) INFORMATION AND REFERRAL.

(g) IN-HOME SERVICES.

5. PUBLIC INFORMATION RESOURCES ON MENTAL RETARDATION.

~~10.~~ 6. Training and practicum programs in conjunction with other state agencies and universities and colleges for teachers, psychologists, social workers, medical personnel and others interested in the field of retardation.

~~11.~~ 7. Research laboratory in the fields of behavioral services and abstract research.

~~12.--Recreation-and-leisure-time-facility-for-retardates-residing in-the-community-who-need-services-of-a-specialized-recreation-program.~~

D. ~~Nonresidential~~ Services of a ~~center~~ FACILITY ~~shall~~ MAY not supplant existing community services provided through other local, city~~,~~ or state resources.

E. ~~Centers~~ THE DEPARTMENT shall stimulate, cooperate with and promote the development of community programs through existing resources, and provide consultation wherever needed.

Sec. 20. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding section 36-558.01, to read:

36-558.01. Operation, support and supervision of special foster homes; duties of department

A. THE DEPARTMENT SHALL OPERATE DIRECTLY OR SUPPORT AND SUPERVISE SPECIAL FOSTER HOMES TO PROVIDE SPECIALIZED FOSTER CARE TO MENTALLY RETARDED PERSONS. SUCH HOMES SHALL BE OPERATED FOR PERSONS PLACED PURSUANT TO SECTIONS 8-241 AND 8-514.01 AND FOR APPROPRIATE PLACEMENTS FOR PERSONS FOR WHOM APPLICATION FOR RESIDENTIAL SERVICES HAS BEEN MADE TO THE DEPARTMENT.

B. IN FURTHERANCE OF ITS RESPONSIBILITY PURSUANT TO SUBSECTION A, THE DEPARTMENT SHALL RECRUIT, LICENSE AND SUPPORT SUCH HOMES IN ACCORDANCE WITH THE PROVISIONS OF TITLE 8, CHAPTER 5, ARTICLE 1, AND THE PROVISIONS OF THIS CHAPTER, MAINTAIN REGULAR SUPERVISION OF SUCH HOMES AND SUCH PLACEMENTS, CONDUCT TRAINING PROGRAMS FOR THE STAFF OF SUCH HOMES AND DEVELOP THE PROGRAM AND SERVICE STANDARDS FOR MENTALLY RETARDED PERSONS TO BE PLACED IN SUCH HOMES.

C. SPECIAL FOSTER HOMES SUPPORTED BY THE DEPARTMENT SHALL BE PAID FOR EACH MENTALLY RETARDED PERSON PLACED THEREIN AN AMOUNT DETERMINED BY THE DEPARTMENT BASED ON THE LEVEL OF MENTAL RETARDATION AND THE CONSEQUENT NEED FOR PROGRAMS AND SERVICES OF EACH PERSON SO PLACED.

Sec. 21. Section 36-559, Arizona Revised Statutes, is amended to read:

36-559. Eligibility for mental retardation programs, services and facilities

A mentally retarded person ~~may-be~~ IS eligible TO APPLY for ~~admission-for-residential-care-at-a-center~~ MENTAL RETARDATION PROGRAMS, SERVICES AND FACILITIES OPERATED BY, LICENSED AND SUPERVISED BY, OR SUPPORTED BY THE DEPARTMENT if such person:

1. Is a bona fide resident of the state of Arizona.

~~2.--Is-free-from-any-communicable-disease.~~

~~3,~~ 2. Is mentally retarded ~~to-such-an-extent-that-he-will-benefit from-the-care,-treatment,-and-services-available-at-the-center~~ AS DEFINED IN THIS CHAPTER AND PROVIDES MEDICAL AND PSYCHOLOGICAL DOCUMENTATION OF SUCH MENTAL RETARDATION UTILIZING TESTS WHICH ARE CULTURALLY APPROPRIATE AND VALID, OR IS AN INFANT AND AS A RESULT OF TESTS PERFORMED PURSUANT TO SECTION 36-694, OR OTHER APPROPRIATE TESTS, THERE IS STRONGLY DEMONSTRATED POTENTIAL THAT THE INFANT IS MENTALLY RETARDED OR WILL BECOME MENTALLY RETARDED.

Sec. 22. Repeal

Sections 36-560 and 36-561, Arizona Revised Statutes, are repealed.

Sec. 23. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding sections 36-560 and 36-561, to read:

36-560. Admission

A. PERSONS SHALL BE ADMITTED TO MENTAL RETARDATION PROGRAMS OR SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT ONLY PURSUANT TO THE PROCEDURES PRESCRIBED IN THIS CHAPTER. AN APPLICATION FOR ADMISSION SHALL BE SUBMITTED ON FORMS PROVIDED BY THE DEPARTMENT IN ACCORDANCE WITH THE RULES AND PROCEDURES ADOPTED BY THE DEPARTMENT.

B. ADMISSION INTO ANY MENTAL RETARDATION PROGRAM OR SERVICE OPERATED BY THE DEPARTMENT OR SUPPORTED BY THE DEPARTMENT SHALL BE SUBJECT TO AVAILABILITY OF SPACE IN SUCH PROGRAM OR SERVICE AND SHALL BE SUBJECT TO ANNUAL LEGISLATIVE APPROPRIATION AND OTHER AVAILABLE FUNDING.

C. NO PERSON SHALL RECEIVE MENTAL RETARDATION SERVICES UNLESS PROOF OF THE REQUIREMENTS SET FORTH IN SECTION 36-559 IS PROVIDED.

D. AN APPLICATION SHALL BE SIGNED BY THE RESPONSIBLE PERSON. NO ADMISSION OR ASSIGNMENT OF ANY CLIENT TO A PROGRAM, SERVICE OR FACILITY MAY BE MADE WITHOUT THE CONSENT OF THE RESPONSIBLE PERSON. IF AN APPLICATION FOR ADMISSION TO A RESIDENTIAL PROGRAM IS MADE FOR A CLIENT FOURTEEN TO EIGHTEEN YEARS OF AGE, CAPABLE OF GIVING VOLUNTARY INFORMED CONSENT, THEN SUCH CLIENT AND HIS PARENT OR GUARDIAN SHALL JOINTLY APPLY, UNLESS IT APPEARS TO THE DEPARTMENT THAT SUCH CLIENT IS MANIFESTLY INCAPABLE OF GIVING SUCH CONSENT. AN ADULT CAPABLE OF GIVING CONSENT MAY APPLY FOR ADMISSION AND BE ASSIGNED TO PROGRAMS, SERVICES OR FACILITIES.

E. IF AN ADULT APPLICANT APPLIES FOR ADMISSION, OR WHEN A MINOR CLIENT SERVED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT BECOMES EIGHTEEN YEARS OF AGE, AND SUCH APPLICANT OR CLIENT REASONABLY APPEARS TO BE IMPAIRED BY MENTAL DEFICIENCY TO THE EXTENT THAT HE LACKS SUFFICIENT UNDERSTANDING OR CAPACITY TO MAKE OR COMMUNICATE RESPONSIBLE DECISIONS CONCERNING HIS PERSON, THE DEPARTMENT SHALL REQUIRE THAT PRIOR TO RECEIVING OR CONTINUING TO RECEIVE MENTAL RETARDATION PROGRAMS OR SERVICES, THE APPLICANT HAVE A GUARDIAN APPOINTED PURSUANT TO TITLE 14, CHAPTER 5, OR SHALL HAVE HAD A JUDICIAL DETERMINATION MADE THAT IT IS NOT NECESSARY TO APPOINT A GUARDIAN FOR SUCH PERSON.

F. THERE SHALL BE NO JUDICIAL ADMISSIONS EXCEPT IN ACCORDANCE WITH SECTION 8-242.

G. NO PERSON MAY BE ADMITTED OR ASSIGNED TO ANY MENTAL RETARDATION FACILITY, PROGRAM OR SERVICE UNLESS SUCH PERSON HAS RECEIVED A PLACEMENT EVALUATION TO DETERMINE THE NEED FOR THE MENTAL RETARDATION PROGRAMS AND

SERVICES WHICH ARE APPROPRIATE FOR SUCH PERSON AND THE ADMITTANCE OR ASSIGNMENT IS CONSISTENT WITH THE RECOMMENDATION OR PLACEMENT EVALUATION, AND EACH PLACEMENT EVALUATION SHALL BE GOVERNED BY THE FOLLOWING CONDITIONS:

1. THE PLACEMENT EVALUATION TEAM SHALL CONSIST OF A GROUP ASSIGNED BY THE DEPARTMENT WHICH SHALL INCLUDE A DEPARTMENT EMPLOYEE TO SERVE AS THE CASE MANAGER, THE PARENT OR GUARDIAN OF THE APPLICANT AND APPROPRIATE PROGRAM STAFF OF THE DEPARTMENT. COUNSEL FOR THE APPLICANT AND A FRIEND OR ADVOCATE OF THE APPLICANT DESIGNATED IN THE APPLICATION FOR ADMISSION MAY ALSO ATTEND THE EVALUATION SESSIONS FOR THE APPLICANT.

2. A PLACEMENT EVALUATION REPORT SHALL BE PREPARED WITHIN THIRTY DAYS AFTER THE PLACEMENT EVALUATION IS INITIATED WHICH SHALL RECOMMEND THE ASSIGNMENT OF THE APPLICANT TO CERTAIN DESIGNATED TYPES OF MENTAL RETARDATION PROGRAMS OR SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT. IN THIS PROCESS THE SPECIFIC ASSIGNMENT REQUEST OF THE RESPONSIBLE PERSON SHALL BE GIVEN STRONG CONSIDERATION.

3. A PLACEMENT EVALUATION CONDUCTED BY THE DEPARTMENT FOR THE PURPOSE OF DETERMINING APPROPRIATE MENTAL RETARDATION PROGRAMS AND SERVICES SHALL NOT INCLUDE AN EVALUATION OF A CHILD FOR PLACEMENT IN A SPECIAL EDUCATION PROGRAM IN A SCHOOL DISTRICT.

H. THE STANDARDS FOR DETERMINING THE ASSIGNMENT FOR THE APPLICANT TO A PARTICULAR SERVICE SHALL BE IN THE BEST INTEREST OF THE CLIENT, TAKING INTO CONSIDERATION THE AGE, DEGREE OF MENTAL RETARDATION, THE PRESENCE OF OTHER HANDICAPPING CONDITIONS OF THE APPLICANT, THE ABILITY TO PROVIDE SUCH APPLICANT WITH THE MAXIMUM OPPORTUNITY TO DEVELOP HIS OR HER MAXIMUM POTENTIAL, TO PROVIDE A MINIMALLY STRUCTURED RESIDENTIAL PROGRAM AND ENVIRONMENT FOR THE APPLICANT AND TO PROVIDE A SAFE, SECURE, AND DEPENDABLE RESIDENTIAL AND PROGRAM ENVIRONMENT FOR THE APPLICANT AND THE PARTICULAR DESIRES OF THE APPLICANT. IN MAKING SUCH DETERMINATION, THE PLACEMENT EVALUATION TEAM SHALL CONSIDER THE REPORTS OF ALL PREVIOUS PLACEMENT-TYPE EVALUATIONS PERFORMED FOR SUCH APPLICANT, THE MEDICAL AND PROGRAM HISTORY OF THE APPLICANT, AND THE SERVICES AND PROGRAMS AVAILABLE FROM THIS STATE, CONTRACTORS OF THIS STATE AND OTHER PROVIDERS.

I. AFTER SUCH PLACEMENT EVALUATION REPORT HAS BEEN ISSUED AND THE RESPONSIBLE PERSON ACCEPTS THE ASSIGNMENT OF ALL SUCH PROGRAMS OR SERVICES, THE DEPARTMENT SHALL ENROLL THE APPLICANT IN THE PROGRAMS OR SERVICES WITHIN THIRTY DAYS, SUBJECT TO THE PROVISIONS OF SUBSECTION B. IF THE APPLICANT CANNOT BE ENROLLED WITHIN THIRTY DAYS, WRITTEN AND ORAL NOTICE, SUBJECT TO THE REQUIREMENTS OF SECTION 36-551.01, SUBSECTION P, SHALL BE GIVEN TO THE APPLICANT AND THE RESPONSIBLE PERSON, WITHIN TEN DAYS OF THE DEPARTMENT'S DETERMINATION THAT THE APPLICANT CANNOT BE ENROLLED, INFORMING SUCH PERSONS OF THE DEPARTMENT'S DETERMINATION. THE NOTICE SHALL ALSO INCLUDE THE APPROPRIATE PROCEDURES WHICH THE APPLICANT OR THE RESPONSIBLE PERSON SHOULD FOLLOW TO ASSURE THAT THE APPLICANT IS ENROLLED.

J. THE DEPARTMENT MAY ATTACH CONDITIONS TO THE DIRECT OR INDIRECT PROVISION OF SERVICES WITH WHICH THE CLIENT WOULD BE REQUIRED TO COMPLY IN ORDER TO RECEIVE SUCH SERVICES. SUCH CONDITIONS MAY INCLUDE REQUIRING

THE CLIENT TO PARTICIPATE IN APPROPRIATE DAY PROGRAMS AS A CONDITION OF PROVIDING RESIDENTIAL SERVICES AND RESIDENTIAL FACILITIES. A CLIENT ASSIGNED TO A RESIDENTIAL PROGRAM MAY BE REQUIRED TO ASSIST IN DAILY HOUSEWORK IN MAINTAINING SUCH FACILITY AS PART OF THE CLIENT'S INDIVIDUAL PROGRAM.

K. THE DEPARTMENT MAY REFUSE TO PROVIDE SPECIFIC SERVICES REQUESTED BY THE CLIENT WHICH ARE NOT RECOMMENDED FOR THE CLIENT AS A RESULT OF THE EVALUATION.

L. APPLICATION FOR ADMISSION SHALL BE ONE OF THE FOLLOWING TYPES:

1. "REGULAR ADMISSION" FOR PLACEMENT OF A MENTALLY RETARDED PERSON FOR MENTAL RETARDATION PROGRAMS AND SERVICES AFTER A PLACEMENT EVALUATION HAS BEEN CONDUCTED FOR SUCH PERSON.

2. "EMERGENCY ADMISSION" FOR PLACEMENT OF A MENTALLY RETARDED PERSON WHEN THERE IS AN IMMEDIATE AND COMPELLING NEED FOR SHORT-TERM MENTAL RETARDATION PROGRAMS AND SERVICES.

M. REGULAR ADMISSION SHALL BE PERMITTED ONLY AFTER A PLACEMENT EVALUATION HAS BEEN CONDUCTED AND ONLY IF SPACE IS AVAILABLE AT THE FACILITY OR IN THE PROGRAM OR SERVICE IN WHICH PLACEMENT IS REQUESTED.

N. EMERGENCY ADMISSION FOR MENTALLY RETARDED APPLICANTS SHALL BE PERMITTED EVEN THOUGH A PLACEMENT EVALUATION HAS NOT BEEN PERFORMED, IF:

1. SPACE IS AVAILABLE AT THE FACILITY OR IN THE PROGRAM OR SERVICE IN WHICH PLACEMENT IS REQUESTED.

2. THE DEPARTMENT DETERMINES THAT THE FACILITY PROGRAM OR SERVICE WILL MEET THE NEEDS OF THE CLIENT.

3. THE CLIENT HAS AN URGENT NEED FOR SHORT-TERM PLACEMENT AND CARE WHICH THE FACILITY, PROGRAM OR SERVICE PROVIDES AND IS OTHERWISE ELIGIBLE FOR SERVICES PURSUANT TO THE REQUIREMENTS SET FORTH IN SECTION 36-559.

O. MENTAL RETARDATION PROGRAMS AND SERVICES MAY BE PROVIDED TO A MENTALLY RETARDED PERSON ADMITTED PURSUANT TO AN EMERGENCY ADMISSION FOR A PERIOD NOT TO EXCEED SIXTY CONSECUTIVE DAYS FOLLOWING ADMISSION OR UNTIL A PLACEMENT EVALUATION IS PERFORMED, WHICHEVER PERIOD FIRST OCCURS.

36-561. Prohibiting certain treatment or drugs; use of aversive stimuli

A. NO PSYCHOSURGERY, INSULIN SHOCK OR ELECTROSHOCK TREATMENT OR EXPERIMENTAL DRUGS SHALL BE ADMINISTERED BY THE DEPARTMENT TO ANY CLIENT, NOR SHALL THE DEPARTMENT LICENSE, APPROVE OR SUPPORT ANY PROGRAM OR SERVICE WHICH USES SUCH TREATMENT OR DRUGS.

B. THE DEPARTMENT SHALL ADOPT RULES AND REGULATIONS SPECIFYING THE AVERSIVE STIMULI USED FOR ANY MENTAL RETARDATION PROGRAM OR SERVICE PROVIDED DIRECTLY BY, LICENSED AND SUPERVISED BY, OR SUPPORTED BY THE DEPARTMENT. COPIES OF SUCH RULES AND REGULATIONS SHALL BE MADE AVAILABLE TO ALL PARENTS, GUARDIANS, APPLICANTS AND CLIENTS PARTICIPATING IN PLACEMENT EVALUATIONS. THE DEPARTMENT SHALL PROVIDE AT LEAST SIXTY DAYS NOTICE TO ALL RESPONSIBLE PERSONS PRIOR TO IMPLEMENTING ANY MODIFICATION TO SUCH RULES AND REGULATIONS. NO AVERSIVE STIMULI SHALL BE USED OR PERMITTED BY THE DEPARTMENT IN ANY SUCH PROGRAM OR SERVICE EXCEPT IN ACCORDANCE WITH THE ADOPTED RULES AND REGULATIONS AND THE CLIENT'S INDIVIDUAL PROGRAM PLAN.

Sec. 24. Section 36-562, Arizona Revised Statutes, is amended to read:

36-562. Schedule of financial contribution; review of payment order

A. Money for the support of a mentally retarded person IN A RESIDENTIAL PROGRAM OPERATED OR SUPPORTED BY THE DEPARTMENT, EXCEPT FOR CHILDREN PLACED IN SPECIAL FOSTER HOMES AS DESCRIBED IN SECTION 36-514.01, PURSUANT TO SECTIONS 8-241, 8-242 AND 8-514.01 shall be paid to the department, and by it deposited with the state treasurer, and shall continue to be paid unless and until the person is discharged from ~~the-center-as provided-in-section-36-566~~ SUCH RESIDENTIAL PROGRAM. Credit shall be given for any periods of temporary absence, such as for home visits, vacations, or other purposes.

B. The financial contribution by the parent~~,-spouse,-guardian-or guardian-of-the-estate~~ OF A MENTALLY RETARDED MINOR shall terminate ~~after sixteen-years-of-actual-care-of-the-child-for-which-payment-has-been satisfactorily-made,-which-period-of-time-shall-include-the-time-for which-such-payments-were-made-for-such-child-prior-to-the-effective-date of-this-subsection~~ UPON THE EIGHTEENTH BIRTHDAY OF SUCH PERSON. THE FINANCIAL CONTRIBUTION BY PARENTS ON BEHALF OF TWO OR MORE MENTALLY RETARDED PERSONS RECEIVING MENTAL RETARDATION PROGRAMS OR SERVICES SHALL NOT EXCEED THE MAXIMUM AMOUNT SUCH PARENTS WOULD BE REQUIRED TO PAY IF ONLY ONE OF SUCH CHILDREN WERE RECEIVING THE PROGRAMS OR SERVICES.

C. The amount of annual liability of a mentally retarded person~~,~~- OR his estate~~,~~- OR parent~~,-or-guardian-of-the-estate~~ for MENTAL RETARDATION residential ~~care~~ SERVICES PROVIDED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT shall be based on the percentage of gross income of the mentally retarded person, his estate~~,~~- OR parent ~~or-guardian~~, as defined by section 43-112(a), except that part of the gross income of a self-employed person which results from the operation of his business shall be adjusted as prescribed by the terms of section 43-112(f), as follows:

GROSS INCOME	PER CENT
~~0--4,999~~	~~0.0~~
~~5,000--5,999~~	~~3.5~~
~~6,000--6,999~~	~~4.0~~
~~7,000--7,999~~	~~4.25~~
~~8,000--8,999~~	~~5.0~~
~~9,000--9,999~~	~~5.75~~
~~10,000-10,999~~	~~6.25~~
~~11,000-11,999~~	~~6.75~~
~~12,000-12,999~~	~~7.0~~
~~13,000-13,999~~	~~7.25~~
~~14,000-14,999~~	~~7.50~~
~~15,000-15,999~~	~~7.75~~
~~16,000-16,999~~	~~8.0~~
~~17,000-17,999~~	~~8.25~~
~~18,000-18,999~~	~~8.50~~
~~19,000-19,999~~	~~8.75~~

GROSS INCOME	PER CENT
~~20,000-20,999~~	~~9.0~~
~~21,000-21,999~~	~~9.25~~
~~22,000 or more~~	~~9.50~~
0- 9,999	0.0
10,000-10,999	3.50
11,000-11,999	4.00
12,000-12,999	4.25
13,000-13,999	5.00
14,000-14,999	5.75
15,000-15,999	6.25
16,000-16,999	6.75
17,000-17,999	7.00
18,000-18,999	7.25
19,000-19,999	7.50
20,000-20,999	7.75
21,000-21,999	8.00
22,000-22,999	8.25
23,000-23,999	8.50
24,000-24,999	8.75
25,000-25,999	9.00
26,000-26,999	9.25
27,000-OR MORE	9.50

But not to exceed ~~$2,100.00~~ $2,600.00 annually.

The schedule as prescribed by this subsection shall apply to each mentally retarded person, but in no event shall the total obligation of the person~~,~~ OR his estate~~,~~ OR parent~~, or guardian~~ exceed ~~one hundred seventy-five~~ TWO HUNDRED SIXTEEN dollars per month.

D. The director shall review his order for payment for residential care at least annually, AND SHALL REQUIRE THE RESPONSIBLE PERSON TO ANNUALLY UPDATE THE FINANCIAL INFORMATION PROVIDED AT THE TIME OF INITIAL APPLICATION FOR MENTAL RETARDATION SERVICES or at any time upon request for review by the county board of supervisors or by the parent, guardian, or other person making such payments. The provisions of section ~~36-561~~ 36-563, ~~subsection B~~ shall apply to any order or change in order for payment.

E. The ~~mentally retarded person, his estate, parent, or guardian~~ RESPONSIBLE PERSON shall furnish AT THE TIME INITIAL APPLICATION FOR MENTAL RETARDATION SERVICES IS MADE current financial information to the director and to the appropriate county board of supervisors at the times and on the forms and in the manner prescribed by the board, provided that such information shall be held by the director and the county board of supervisors to be strictly confidential and it shall not be divulged except in the instance where it is necessary in connection with legal action.

~~F. Any person or county liable for support of a child or person under this section may appeal to the board from any order of the director for payment of support as provided in section 36-563. If the order of~~

~~support-was-made-by-a-court,-a-petition-may-be-filed-with-such-court requesting-that-the-amount-of-liability-for-such-support-be-reduced. The-court-may-after-a-hearing-on-such-petition,-determine-whether-or not-such-liability-shall-be-reduced-because-of-such-hardship.~~

F. NO FINANCIAL CONTRIBUTION SHALL BE REQUESTED FROM THE CLIENT OR THE PARENT, SPOUSE, OR ESTATE OF A MENTALLY RETARDED PERSON FOR THE COST OF ANY NONRESIDENTIAL MENTAL RETARDATION PROGRAM OR SERVICE OPERATED BY OR SUPPORTED BY THE DEPARTMENT.

G. THE AMOUNT PAYABLE BY THE MENTALLY RETARDED PERSON OR HIS PARENT OR ESTATE FOR RESIDENTIAL CARE SHALL BE FIXED BY THE DIRECTOR IN ACCORDANCE WITH THE FEES PRESCRIBED IN THIS SECTION. THE COUNTY IN WHICH THE MENTALLY RETARDED PERSON RESIDES SHALL PAY THAT PORTION OF THE ACTUAL COST OF RESIDENTIAL CARE AND MAINTENANCE OVER AND ABOVE THE AMOUNT ORDERED PAID BY THE MENTALLY RETARDED PERSON OR HIS PARENT OR ESTATE, PROVIDED THAT IN NO EVENT SHALL THE TOTAL COMBINED OBLIGATION OF THE COUNTY AND THE PERSON OR HIS PARENT OR ESTATE EXCEED TWO HUNDRED SIXTEEN DOLLARS EACH MONTH FOR SUCH PERSON, AND THE TOTAL OBLIGATION OF THE COUNTY SHALL NOT EXCEED ONE HUNDRED SEVENTY-FIVE DOLLARS PER MONTH FOR EACH PERSON. THE DIRECTOR SHALL NOTIFY THE COUNTY BOARD OF SUPERVISORS OF THE DATE OF ADMISSION OF THE MENTALLY RETARDED PERSON.

H. MONEY PAID BY A CLIENT, PARENT OR GUARDIAN SHALL BE PAID TO THE DIRECTOR AND DEPOSITED WITH THE STATE TREASURER IN THE GENERAL FUND.

I. THE DEPARTMENT SHALL PROVIDE MONTHLY BILLINGS TO ALL PERSONS AND COUNTIES RESPONSIBLE FOR PAYING FOR MENTAL RETARDATION SERVICES AND PROGRAMS PROVIDED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT. THE DEPARTMENT SHALL REQUIRE ALL PURCHASE OF CARE PROVIDERS TO PROVIDE CURRENT LISTS OF ALL PERSONS RECEIVING RESIDENTIAL CARE IN FACILITIES OPERATED BY SUCH PERSONS. THE DEPARTMENT SHALL FORWARD REPORTS OF DELINQUENT BILLINGS FOR RESIDENTIAL SERVICES PROVIDED BY THE DEPARTMENT OR BY CONTRACTORS TO THE ATTORNEY GENERAL FOR COLLECTION.

J. THE DEPARTMENT SHALL NOTIFY EACH CLIENT AND THE PARENT OR GUARDIAN OF SUCH CLIENT FOR WHOM IT HAS DETERMINED THAT CONTRIBUTIONS ARE REQUIRED FOR THE COST OF RESIDENTIAL CARE, THAT IT RESERVES THE RIGHT TO TERMINATE MENTAL RETARDATION RESIDENTIAL CARE TO A CLIENT FOR NONPAYMENT OF FEES REQUIRED TO BE PAID PURSUANT TO THIS SECTION.

K. ANY PERSON OR COUNTY AFFECTED BY AN ORDER OF THE DIRECTOR FOR PAYMENT OF COSTS OF CARE MAY CONTEST SUCH ORDER AND REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO SECTION 36-563. ANY PERSON LIABLE FOR THE COSTS OF CARE OF A CLIENT, MAY APPEAL TO THE DIRECTOR, PURSUANT TO SECTION 36-563, FOR A REDUCTION IN THE AMOUNT OF PAYMENT FOR SUCH COSTS OF CARE ON THE BASIS OF HARDSHIP.

L. THE PROVISIONS OF SUBSECTIONS C AND G NOTWITHSTANDING, THE DEPARTMENT MAY REQUIRE CLIENTS WHO ARE RESIDENTS OF COMMUNITY RESIDENTIAL ALTERNATIVES AND WHO RECEIVE INCOME OR BENEFITS TO CONTRIBUTE TO THE COST OF THEIR SUPPORT AND MAINTENANCE, SUBJECT TO THE PROVISIONS OF FEDERAL LAWS AND REGULATIONS. SUCH CONTRIBUTIONS SHALL NOT BE SUBJECT TO THE PROVISIONS OF SUBSECTIONS A AND H. THE DEPARTMENT SHALL PROMULGATE RULES AND REGULATIONS WHICH DETERMINE THE AMOUNT AND MEANS

OF PAYMENT OF SUCH CONTRIBUTIONS, EXCEPT THAT IN NO EVENT SHALL THE COMBINED CONTRIBUTION MADE ON BEHALF OF A CLIENT BY A CLIENT, HIS OR HER PARENT OR ESTATE EXCEED TWO HUNDRED SIXTEEN DOLLARS PER MONTH. THE PROVISIONS OF SUBSECTION G NOTWITHSTANDING, ANY CONTRIBUTION MADE BY A CLIENT PURSUANT TO THIS SUBSECTION, SHALL NOT BE CONSIDERED IN DETERMINING THE PAYMENT OBLIGATION OF A COUNTY. THE RULES AND REGULATIONS PROMULGATED UNDER THIS SUBSECTION SHALL PROVIDE THAT A PORTION OF THE CLIENT'S INCOME OR BENEFITS SHALL BE RETAINED FOR HIS OR HER PERSONAL USE.

Sec. 25. Repeal

Section 36-563, Arizona Revised Statutes, is repealed.

Sec. 26. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding a new section 36-563, to read:

36-563. Review and appeal; hearing

A. THE PROVISIONS OF THIS SECTION SHALL GOVERN, FOR THIS CHAPTER, THE REVIEW AND APPEAL PROCEDURE FOR DECISIONS RELATING TO THE ADMISSION, EVALUATION, ASSIGNMENT TO PROGRAMS AND SERVICES, CARE AND TREATMENT, DISCHARGE FROM A PROGRAM OR SERVICE PROVIDED THROUGH THE DEPARTMENT AND CONTRIBUTIONS FOR RESIDENTIAL PROGRAMS OR SERVICES PROVIDED THROUGH THE DEPARTMENT.

B. NOTICE OF THE APPEAL RIGHTS PROVIDED PURSUANT TO THIS SECTION SHALL BE GIVEN TO ALL PARTIES TO EACH PLACEMENT EVALUATION AND TO EACH INTERESTED PERSON UPON REQUEST.

C. THE DIRECTOR SHALL ADOPT RULES AND REGULATIONS WHICH ESTABLISH PROCEDURES FOR INITIAL, INFORMAL ADMINISTRATIVE REVIEW AND REDETERMINATION BY THE DEPARTMENT OF THE DECISIONS SPECIFIED IN SUBSECTION A. SUCH REGULATIONS SHALL SPECIFY THE MANNER BY WHICH REQUESTS FOR ADMINISTRATIVE REVIEWS ARE FILED, THE PERSON WITH WHOM SUCH REQUESTS ARE FILED, WHETHER, AND UNDER WHAT CIRCUMSTANCES MEETINGS OF DEPARTMENT REPRESENTATIVES AND THE PERSON FILING THE REQUEST ARE REQUIRED TO BE HELD TO CONSIDER SUCH REQUESTS FOR REVIEW AND THE TIME PERIODS GOVERNING SUCH REQUESTS AND WHICH GOVERN DECISIONS ON SUCH REQUESTS. SUCH RULES AND REGULATIONS MAY PRESCRIBE FORMS TO BE USED IN INITIATING REQUESTS FOR ADMINISTRATIVE REVIEW.

D. FURTHER ADMINISTRATIVE APPEALS FROM DECISIONS OF THE DEPARTMENT SUBJECT TO THE PROCEDURES SPECIFIED IN SUBSECTION C AND ON OTHER CONTESTED CASES SHALL BE GOVERNED BY THE PROVISIONS OF TITLE 41, CHAPTER 14, ARTICLE 3.

Sec. 27. Repeal

Section 36-564, Arizona Revised Statutes, is repealed.

Sec. 28. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding a new section 36-564, to read;

36-564. Guardianship

A. GUARDIANS FOR CLIENTS ACTING UNDER THE PROVISIONS OF THIS CHAPTER SHALL BE APPOINTED PURSUANT TO TITLE 14, CHAPTER 5, ARTICLES 1, 2, 3 AND 6.

B. THE DEPARTMENT SHALL REQUEST THE APPOINTMENT OF A GUARDIAN FOR MINOR CLIENTS RECEIVING SERVICES UNDER THE PROVISIONS OF THIS CHAPTER IF NO PARENT IS WILLING AND COMPETENT TO ACT, AND SHALL REQUEST THE

APPOINTMENT OF A GUARDIAN FOR ADULT CLIENTS RECEIVING SERVICES UNDER THE PROVISIONS OF THIS CHAPTER IF IT APPEARS THAT THE APPOINTMENT OF A GUARDIAN WOULD BE IN THE CLIENT'S BEST INTERESTS IN ACCORDANCE WITH SECTION 14-5304.

C. WHEN NO PERSON OR CORPORATION IS QUALIFIED AND WILLING TO ACT AS GUARDIAN FOR A CLIENT, THE DEPARTMENT SHALL NOTIFY THE PUBLIC FIDUCIARY OF THE COUNTY WHERE THE CLIENT IS RECEIVING SERVICES OF THE NEED FOR APPOINTMENT OF A GUARDIAN.

D. GUARDIANSHIP OR CONSERVATORSHIP FOR MENTALLY RETARDED PERSONS SHALL BE UTILIZED ONLY AS IS NECESSARY TO PROMOTE THE WELL-BEING OF THE INDIVIDUAL, BE DESIGNED TO ENCOURAGE THE DEVELOPMENT OF MAXIMUM SELF-RELIANCE AND INDEPENDENCE IN THE INDIVIDUAL, AND SHALL BE ORDERED ONLY TO THE EXTENT NECESSITATED BY THE INDIVIDUAL'S ACTUAL MENTAL AND ADAPTIVE LIMITATIONS.

Sec. 29. Repeal

Sections 36-565 and 36-566, Arizona Revised Statutes, are repealed.

Sec. 30. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding new sections 36-565 and 36-566, to read:

36-565. Periodic evaluations of mentally retarded persons

A. EVALUATIONS OF THE CLIENT'S PLACEMENT SHALL BE MADE AT SIX-MONTH INTERVALS AFTER A MENTALLY RETARDED CLIENT HAS BEEN ENROLLED IN A MENTAL RETARDATION PROGRAM OR SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT. THE DEPARTMENT, UPON SUCH EVALUATION, SHALL RECOMMEND TO THE RESPONSIBLE PERSON ANY CHANGE IN THE MENTAL RETARDATION PROGRAM OR SERVICE FOR THE MENTALLY RETARDED PERSON, IN ACCORDANCE WITH THE RESULTS OF SUCH EVALUATIONS.

B. IF AN EVALUATION HAS BEEN CONDUCTED, AND IT IS DETERMINED THAT THE CLIENT IS IN A PROGRAM OR SERVICE NO LONGER APPROPRIATE TO HIS INDIVIDUAL NEEDS OR THAT HE CAN BE BETTER TREATED AND HABILITATED IN ANOTHER FACILITY, PROGRAM OR SERVICE, THE DEPARTMENT SHALL TRANSFER THE CLIENT TO ANOTHER MENTAL RETARDATION PROGRAM OR SERVICE OR TERMINATE THE CLIENT FROM THE MENTAL RETARDATION PROGRAM OR SERVICE PURSUANT TO THIS CHAPTER OR THE DEPARTMENT MAY RECOMMEND ADDITIONAL SERVICES FOR THE CLIENT AS REPORTED BY THE EVALUATION, AND ENROLL THE CLIENT IN SUCH ADDITIONAL SERVICES.

C. THE CLIENT, PARENT AND GUARDIAN SHALL BE GIVEN THIRTY DAYS WRITTEN NOTICE OF THE PROPOSED TRANSFER, TERMINATION OR SUBSTANTIAL CHANGE OF SERVICES UNDER THIS CHAPTER. THE CLIENT, PARENT AND GUARDIAN SHALL ALSO BE INFORMED IN WRITING OF THE RIGHT TO AN ADMINISTRATIVE REVIEW PURSUANT TO SECTION 36-563 FOR THE PURPOSES OF CONTESTING THE PROPOSED ACTION. IF AN ADMINISTRATIVE REVIEW IS REQUESTED, NO TRANSFER, TERMINATION OR SUBSTANTIAL CHANGE OF SERVICES SHALL BE MADE UNTIL THE DECISION RESULTING FROM THE REVIEW IS ISSUED.

D. THE DEPARTMENT SHALL ESTABLISH RULES AND REGULATIONS CONCERNING THE STANDARDS OF PLACEMENT OF CLIENTS FROM ONE PROGRAM SETTING TO ANOTHER.

36-566. Request for termination from a state facility, program or service

A. UPON WRITTEN REQUEST FROM THE RESPONSIBLE PERSON FOR TERMINATION OF THE CLIENT FROM A MENTAL RETARDATION PROGRAM OR SERVICE OPERATED DIRECTLY OR INDIRECTLY BY THE DEPARTMENT, OR WHEN IT HAS BEEN DETERMINED AT AN EVALUATION THAT THE CLIENT HAS THE NECESSARY INDEPENDENT LIVING SKILLS AS DETERMINED BY THE CLIENT'S INDIVIDUAL PROGRAM PLAN, THE DEPARTMENT SHALL IMMEDIATELY TERMINATE SUCH PROGRAMS AND SERVICES FOR SUCH CLIENT. NOTHING CONTAINED IN THIS SECTION SHALL BE CONSTRUED TO CONFLICT WITH SUBSECTION J OF SECTION 36-560.

B. THE DEPARTMENT SHALL TERMINATE A CLIENT FROM MENTAL RETARDATION PROGRAMS AND SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT AT THE AGE OF EIGHTEEN YEARS UNLESS THE RESPONSIBLE PERSON HAS FILED A WRITTEN APPLICATION FOR THE CONTINUATION OF SERVICES OR PROGRAMS.

C. SIX MONTHS PRIOR TO THE EIGHTEENTH BIRTHDAY OF A CLIENT, THE DEPARTMENT SHALL GIVE WRITTEN AND ORAL NOTICE, SUBJECT TO THE LANGUAGE AND COMMUNICATION REQUIREMENTS OF SECTION 36-551.01, SUBSECTION P, TO THE CLIENT AND THE RESPONSIBLE PERSON. SUCH NOTICE SHALL STATE THAT THE DEPARTMENT IS REQUIRED TO TERMINATE THE CLIENT FROM MENTAL RETARDATION PROGRAMS AND SERVICES OPERATED BY OR SUPPORTED BY THE DEPARTMENT AT THE AGE OF EIGHTEEN YEARS UNLESS THE RESPONSIBLE PERSON HAS FILED A WRITTEN APPLICATION FOR THE CONTINUATION OF SERVICES OR PROGRAMS AND THAT A GUARDIAN MAY BE REQUIRED FOR THE CLIENT PURSUANT TO SECTION 36-560, SUBSECTION E.

Sec. 31. Repeal

Section 36-567, Arizona Revised Statutes, is repealed.

Sec. 32. Section 36-568, Arizona Revised Statutes, is amended to read:

36-568. Exclusion of county charges for clients receiving services from budget and tax limitations

Amounts required to be paid by a county ~~to-the-Arizona-children's-colony-by-sections-36-561,-36-562,-36-563-or-36-570-for-dependent-or-indigent-children-or-persons~~ FOR CLIENTS RECEIVING RESIDENTIAL SERVICES shall be excluded from the budget adopted for the previous fiscal year and from the estimate budget and the adopted budget for the current fiscal year for the purpose of computing the limitations under sections 42-302, 42-303 and 42-304, on the amounts proposed for expenditure or to be raised by direct taxation in the estimate budget of such county for each fiscal year.

Sec. 33. Title 36, chapter 5.1, article 1, Arizona Revised Statutes, is amended by adding section 36-568.01, to read:

36-568.01. Confidentiality of records

A. ALL INFORMATION OBTAINED AND RECORDS PREPARED IN THE COURSE OF PROVIDING ANY SERVICES UNDER THIS CHAPTER TO CLIENTS SHALL BE CONFIDENTIAL AND PRIVILEGED MATTER. SUCH INFORMATION AND RECORDS MAY BE DISCLOSED ONLY:

1. WHEN THE RESPONSIBLE PERSON DESIGNATES IN WRITING PERSONS TO WHOM RECORDS OR INFORMATION MAY BE DISCLOSED.
2. TO THE EXTENT NECESSARY TO MAKE CLAIMS ON BEHALF OF A CLIENT FOR AID, INSURANCE OR MEDICAL ASSISTANCE TO WHICH HE MAY BE ENTITLED.
3. PURSUANT TO COURT ORDER.
4. IN COMMUNICATIONS BETWEEN PROFESSIONAL PERSONS IN THE PROVIDING OF SERVICES OR APPROPRIATE REFERRALS.

5. WHEN SUCH DISCLOSURE IS NECESSARY TO PROTECT AGAINST A CLEAR AND SUBSTANTIAL RISK OF IMMINENT SERIOUS INJURY.

6. TO THE SUPERIOR COURT WHEN A PETITION TO ESTABLISH GUARDIANSHIP FOR THE PERSON IS FILED PURSUANT TO THE PROVISIONS OF TITLE 14, CHAPTER 5.

7. TO OTHER STATE AGENCIES OR BODIES FOR OFFICIAL PURPOSES AND IN SUCH CASES INFORMATION OR RECORDS SHALL BE RELEASED WITHOUT THE DESIGNATION OF THE NAME OF THE CLIENT UNLESS SUCH NAME IS REQUIRED FOR THE OFFICIAL PURPOSES OF STATE AGENCIES OR BODIES REQUESTING SUCH INFORMATION SUCH CASE INFORMATION RECEIVED BY A STATE AGENCY OR BODY SHALL BE MAINTAINED AS CONFIDENTIAL UNLESS A CONSENT TO RELEASE HAS BEEN GIVEN AS PROVIDED IN THIS SECTION.

B. THE PERSON TO WHOM SUCH INFORMATION HAS BEEN RELEASED PURSUANT TO SUBSECTION A SHALL BE PROHIBITED FROM USING OR RELEASING SUCH INFORMATION EXCEPT IN THE PROPER PERFORMANCE OF HIS OR HER DUTIES.

Sec. 34. Section 36-569, Arizona Revised Statutes, is amended to read:

36-569. Prohibitions; violations; classification

~~A.--The-following-acts-are-prohibited:~~

~~1.--Knowingly,-unlawfully-or-improperly-causing-a-person-to-be adjudged-mentally-retarded.~~

~~2.--Procuring-the-escape-of-a-person-from-a-center-or-knowingly concealing-an-escaped-person.~~

~~3.~~ A. Improper, ~~or~~ abusive treatment OR NEGLECT of a mentally retarded person ~~at-a-center~~ IS PROHIBITED. FOR THE PURPOSES OF THIS SECTION:

1. "ABUSIVE TREATMENT" MEANS:

(a) PHYSICAL ABUSE BY INFLICTING PAIN OR INJURY TO A CLIENT. THIS INCLUDES HITTING, KICKING, PINCHING, SLAPPING, PULLING HAIR OR ANY SEXUAL ABUSES.

(b) EMOTIONAL ABUSE WHICH INCLUDES RIDICULING OR DEMEANING A CLIENT, MAKING DEROGATORY REMARKS TO A CLIENT OR CURSING DIRECTED TOWARD A CLIENT.

(c) PROGRAMMATIC ABUSE WHICH IS THE USE OF AN AVERSIVE STIMULI TECHNIQUE THAT HAS NOT BEEN APPROVED AS A PART OF SUCH PERSON'S INDIVIDUAL PROGRAM PLAN AND WHICH IS NOT CONTAINED IN THE RULES AND REGULATIONS ADOPTED PURSUANT TO SUBSECTION B OF SECTION 36-561. THIS INCLUDES ISOLATION OR RESTRAINT OF A CLIENT.

2. "NEGLECT" MEANS:

(a) INTENTIONAL LACK OF ATTENTION TO PHYSICAL NEEDS OF CLIENTS SUCH AS TOILETING, BATHING, MEALS AND SAFETY.

(b) INTENTIONAL FAILURE TO REPORT CLIENT HEALTH PROBLEMS OR CHANGES IN HEALTH CONDITION TO IMMEDIATE SUPERVISOR OR NURSE.

(c) SLEEPING ON DUTY OR ABANDONING WORK STATION.

(d) INTENTIONAL FAILURE TO CARRY OUT A PRESCRIBED TREATMENT PLAN FOR A CLIENT.

B. A person who violates any provision of this section is guilty of a CLASS 2 misdemeanor. ~~,-punishable-by-a-fine-of-not-less-than-two hundred-dollars,-by-imprisonment-for-not-less-than-six-months,-or-both,~~

Sec. 35. Repeal

Section 36-570, Arizona Revised Statutes, is repealed.

Sec. 36. Section 36-571, Arizona Revised Statutes, is amended to read:

36-571. Mental retardation funds; disbursement; federal monies

A. The mental retardation fund shall consist of appropriations and other monies for use for mental retardation. The state treasurer shall receive and disburse monies in the fund upon claims signed by the director or other person in the department designated by the director. Salaries and expenses of the department shall be paid from the fund.

B. The state treasurer shall maintain in separate accounts monies for the department or a ~~center~~ PROGRAM, SERVICE OR FACILITY which are received by gift, grant, bequest or devise, and such monies shall be disbursed for the purposes of and in conformity with the terms of the grant, gift, bequest or devise. Any unexpended balance of such monies shall not revert to the general fund at the end of the fiscal year.

C. Monies for mental retardation purposes received from the federal government or an agency thereof shall be kept in a separate account in the mental retardation fund. Any unexpended and unencumbered balance of federal funds remaining in the mental retardation fund at the end of a fiscal year shall not revert to the general fund.

Sec. 37. Title 36, chapter 5.1, Arizona Revised Statutes, is amended by adding article 2, to read:

ARTICLE 2. DEVELOPMENTAL DISABILITIES

36-581. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "DEVELOPMENTAL DISABILITY" MEANS AUTISM, CEREBRAL PALSY, EPILEPSY OR MENTAL RETARDATION.
2. "RESIDENTIAL FACILITY" MEANS A HOME IN WHICH PERSONS WITH DEVELOPMENTAL DISABILITIES LIVE AND WHICH IS LICENSED, OPERATED, SUPPORTED OR SUPERVISED BY THE DEPARTMENT.

36-582. Residential facilities; zoning; notice; appeal

A. UNRELATED PERSONS LIVING TOGETHER NOTWITHSTANDING, A RESIDENTIAL FACILITY WHICH SERVES SIX OR FEWER PERSONS SHALL BE CONSIDERED A RESIDENTIAL USE OF PROPERTY FOR THE PURPOSES OF ALL LOCAL ZONING ORDINANCES IF SUCH FACILITY PROVIDES CARE ON A TWENTY-FOUR HOUR PER DAY BASIS. THE RESIDENTS AND OPERATORS OF SUCH A FACILITY SHALL BE CONSIDERED A FAMILY FOR THE PURPOSES OF ANY LAW OR ZONING ORDINANCE WHICH RELATES TO THE RESIDENTIAL USE OF PROPERTY. THE LIMITATION OF SIX OR FEWER PERSONS DOES NOT INCLUDE THE OPERATOR OF A RESIDENTIAL FACILITY, MEMBERS OF THE OPERATOR'S FAMILY OR PERSONS EMPLOYED AS STAFF, EXCEPT THAT THE TOTAL NUMBER OF ALL PERSONS LIVING AT THE RESIDENTIAL FACILITY SHALL NOT EXCEED EIGHT.

B. FOR THE PURPOSE OF ALL LOCAL ORDINANCES, A RESIDENTIAL FACILITY WHICH SERVES SIX OR FEWER PERSONS SHALL NOT BE INCLUDED WITHIN THE DEFINITION OF ANY TERM WHICH IMPLIES THAT THE RESIDENTIAL FACILITY DIFFERS IN ANY WAY FROM A SINGLE FAMILY RESIDENCE.

C. THE PROVISIONS OF THIS SECTION SHALL NOT BE CONSTRUED TO FORBID ANY CITY, COUNTY OR OTHER LOCAL PUBLIC ENTITY FROM PLACING RESTRICTIONS ON BUILDING HEIGHTS, SETBACK, LOT DIMENSIONS AND PLACEMENTS OF SIGNS OF

A RESIDENTIAL FACILITY WHICH SERVES SIX OR FEWER PERSONS AS LONG AS SUCH RESTRICTIONS ARE IDENTICAL TO THOSE APPLIED TO OTHER SINGLE FAMILY RESIDENCES.

D. THE PROVISIONS OF THIS SECTION SHALL NOT BE CONSTRUED TO FORBID THE APPLICATION TO A RESIDENTIAL FACILITY OF ANY LOCAL ORDINANCE WHICH DEALS WITH HEALTH AND SAFETY, BUILDING STANDARDS, ENVIRONMENTAL IMPACT STANDARDS, OR ANY OTHER MATTER WITHIN THE JURISDICTION OF A LOCAL PUBLIC ENTITY PROVIDED THAT SUCH ORDINANCE DOES NOT DISTINGUISH RESIDENTIAL FACILITIES WHICH SERVE SIX OR FEWER PERSONS FROM OTHER SINGLE FAMILY DWELLINGS AND PROVIDED FURTHER THAT SUCH ORDINANCE DOES NOT DISTINGUISH RESIDENTS OF SUCH RESIDENTIAL FACILITIES FROM PERSONS WHO RESIDE IN OTHER SINGLE FAMILY DWELLINGS.

E. A LOCAL ORDINANCE WHICH DISTINGUISHES, TENDS TO DISTINGUISH, OR HAS THE EFFECT OF DISTINGUISHING RESIDENTIAL FACILITIES WHICH SERVE SIX OR FEWER PERSONS FROM SINGLE FAMILY DWELLINGS SHALL BE VOID AND OF NO EFFECT AS APPLIED TO SUCH FACILITIES.

F. NO CONDITIONAL USE PERMIT, ZONING VARIANCE, OR OTHER ZONING CLEARANCE SHALL BE REQUIRED OF A RESIDENTIAL FACILITY WHICH SERVES SIX OR FEWER PERSONS WHICH IS NOT REQUIRED OF A SINGLE FAMILY RESIDENCE IN THE SAME ZONE.

G. FOR THE PURPOSES OF ANY CONTRACT, DEED, OR COVENANT FOR THE TRANSFER OF REAL PROPERTY EXECUTED SUBSEQUENT TO THE EFFECTIVE DATE OF THIS SECTION, A RESIDENTIAL FACILITY WHICH SERVES SIX OR FEWER PERSONS SHALL BE CONSIDERED A RESIDENTIAL USE OF PROPERTY AND A USE OF PROPERTY BY A SINGLE FAMILY, NOTWITHSTANDING ANY DISCLAIMERS TO THE CONTRARY.

H. NO RESIDENTIAL FACILITY SHALL BE ESTABLISHED WITHIN A TWELVE HUNDRED FOOT RADIUS OF AN EXISTING RESIDENTIAL FACILITY IN A RESIDENTIAL AREA.

I. PRIOR TO THE ESTABLISHMENT OF A RESIDENTIAL FACILITY IN A RESIDENTIAL AREA, THE DEPARTMENT SHALL GIVE AT LEAST SIXTY DAYS WRITTEN NOTICE TO THE LOCAL GOVERNMENT UNIT AFFECTED. THE GOVERNMENT UNIT SHALL HAVE THE RIGHT TO CONTEST THE ESTABLISHMENT OF A RESIDENTIAL FACILITY IN A RESIDENTIAL AREA BY WRITTEN OBJECTION FILED WITH THE DEPARTMENT WITHIN THIRTY DAYS AFTER RECEIVING NOTICE AND MAY REQUEST AN ADMINISTRATIVE HEARING PURSUANT TO TITLE 41, CHAPTER 14, ARTICLE 3.

J. OTHER RESIDENTIAL FACILITIES WHICH SERVE SEVEN OR MORE PERSONS SHALL BE A PERMITTED USE IN ANY ZONE IN WHICH RESIDENTIAL BUILDINGS OF SIMILAR SIZE, CONTAINING ROOMS OR APARTMENTS WHICH ARE PROVIDED ON A CONTINUING BASIS FOR COMPENSATION, ARE A PERMITTED USE. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT ANY CITY OR COUNTY FROM REQUIRING A CONDITIONAL USE PERMIT IN ORDER TO MAINTAIN A RESIDENTIAL FACILITY SERVING SEVEN OR MORE PERSONS, PROVIDED THAT NO CONDITIONS SHALL BE IMPOSED ON SUCH A FACILITY WHICH ARE MORE RESTRICTIVE THAN THOSE IMPOSED ON OTHER SIMILAR DWELLINGS IN THE SAME ZONES.

K. THE PROVISIONS OF THIS ARTICLE SHALL APPLY ONLY TO RESIDENTIAL FACILITIES LICENSED, OPERATED, SUPPORTED OR SUPERVISED BY THE DEPARTMENT AND THE ESTABLISHMENT OF A PARTICULAR FACILITY SHALL NOT CREATE ANY ZONING RIGHTS WITH RESPECT TO ANY SUBSEQUENT USE OF THE PROPERTY INVOLVED.

L. THIS ARTICLE SHALL APPLY ONLY AS TO THOSE GOVERNMENT UNITS WHICH HAVE ADOPTED ZONING ORDINANCES WHICH PLACE MORE RESTRICTIONS ON THE ESTABLISHMENT OF RESIDENTIAL FACILITIES THAN THOSE PERTAINING TO FACILITIES AUTHORIZED UNDER THIS ARTICLE, EXCEPT THAT THE LOCAL GOVERNMENT UNIT TO WHICH THIS ARTICLE DOES NOT OTHERWISE APPLY MAY REQUIRE THE SAME NOTICE AND HEARING PROCEDURES APPLICABLE TO OTHER ZONING MATTERS NOTWITHSTANDING THE PROVISIONS OF SUBSECTION I OF THIS SECTION.

Sec. 38. Section 36-694, Arizona Revised Statutes, is amended to read:

36-694. Report of blood and metabolic tests on birth certificate

A. When a birth or stillbirth is reported, the attending physician or other person required to make a report of the birth shall state on the certificate whether a blood test for syphilis was made upon a specimen of blood taken from the woman who bore the child and the approximate date when the specimen was taken.

B. WHEN A BIRTH IS REPORTED, THE ATTENDING PHYSICIAN OR OTHER PERSON REQUIRED TO MAKE A REPORT ON THE BIRTH SHALL ORDER OR CAUSE TO BE ORDERED TESTS FOR METABOLIC DISORDERS. THESE TESTS SHALL BE SPECIFIED BY RULES AND REGULATIONS OF THE DEPARTMENT OF HEALTH SERVICES. SUCH RULES SHALL BE ADOPTED CONSISTENT WITH THE RECOMMENDATION OF A METABOLIC SCREENING COMMITTEE COMPOSED OF THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SERVING AS CHAIRMAN AND FIVE PHYSICIANS LICENSED UNDER THE PROVISIONS OF TITLE 32, CHAPTERS 13 AND 17 APPOINTED BY THE DIRECTOR WHICH SHALL INCLUDE REPRESENTATION FROM THE MEDICAL SPECIALTIES OF ENDOCRINOLOGY, PEDIATRICS, FAMILY PRACTICE AND OBSTETRICS. THIS METABOLIC SCREENING COMMITTEE SHALL REVIEW ON AN ANNUAL BASIS, OR MORE FREQUENTLY IF DEEMED NECESSARY, THE TESTS WHICH ARE SPECIFIED.

Sec. 39. Title 43, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 43-123.47, to read:

43-123.47. Deduction for expenses paid for mental retardation residential services

FOR ANY TAXABLE YEAR ENDING AFTER DECEMBER 31, 1977 IN COMPUTING NET INCOME, THERE SHALL BE ALLOWED AS A DEDUCTION EXPENSES PAID DURING THE TAXABLE YEAR, NOT COMPENSATED FOR BY INSURANCE OR OTHERWISE, FOR MENTAL RETARDATION RESIDENTIAL SERVICES PURSUANT TO SECTION 36-562 FOR THE TAXPAYER OR A DEPENDENT OF THE TAXPAYER AS DEFINED IN SECTION 43-127, SUBSECTION (c).

Sec. 40. Legislative findings and intent

A. The legislature finds and declares that the health and welfare of the state requires that community-based housing programs for mentally retarded persons should be expanded and should be the foundation of the state's mental retardation residential program. The legislature finds that because of the extreme difficulties in locating such housing programs in residential communities in other states, because of the necessity that this type of housing program be established in Arizona on a state-wide basis, and because of the diversities in Arizona's municipal zoning ordinances, that minimum state-wide standards are required to permit this type of housing to be established in residential communities in this state.

B. The legislature further declares that the cities and counties should be given sufficient time to adopt, pursuant to the applicable city or county procedures, their own regulations as part of their comprehensive planning and zoning ordinances and regulations which meet the minimum standards established by this legislation. Therefore, the legislature has provided that section 37 of this act will not become effective until December 1, 1978.

Sec. 41. Admissions under prior law

A. Clients admitted or committed to facilities or receiving services under the jurisdiction of the department under law previously enforced may remain in such facilities and continue receiving such services until such time as necessary and appropriate alternate placements or services, if required, are found or determined or until such time as they can be readmitted to a facility under the provisions of this chapter if such readmission is necessary to meet the requirements of this chapter.

B. Clients admitted or committed under law previously enforced shall be discharged as soon as practicable after receipt by the department of a written request from the responsible person pursuant to the provisions of this chapter.

Sec. 42. Effective dates

A. The provisions of sections 2, 3, 4, 7, 9, 10, 12, 15, 16, 17, 18, 20, 22, 23, 25, 26, 27, 29, 30, 34 and 35 of this act shall become effective on January 1, 1979.

B. The provisions of section 37 of this act shall become effective on December 1, 1978.

Approved by the Governor - June 7, 1978

Filed in the Office of the Secretary of State - June 8, 1978